



DOCTOR OF HEALTH (DHEALTH)

An exploration into the professional and personal challenges facing migrant and overseas generalist Registered Nurses working and living in two small island communities

Mcclean, Tracey

Award date:
2016

Awarding institution:
University of Bath

[Link to publication](#)

Alternative formats

If you require this document in an alternative format, please contact:
openaccess@bath.ac.uk

Copyright of this thesis rests with the author. Access is subject to the above licence, if given. If no licence is specified above, original content in this thesis is licensed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC-ND 4.0) Licence (<https://creativecommons.org/licenses/by-nc-nd/4.0/>). Any third-party copyright material present remains the property of its respective owner(s) and is licensed under its existing terms.

Take down policy

If you consider content within Bath's Research Portal to be in breach of UK law, please contact: openaccess@bath.ac.uk with the details. Your claim will be investigated and, where appropriate, the item will be removed from public view as soon as possible.

An exploration into the professional and personal challenges facing migrant and overseas generalist Registered Nurses working and living in two small island communities

Tracey Ann McClean

A thesis submitted for the degree of
Professional Doctorate in Health

University of Bath
Department for Health
February 2016

COPYRIGHT

Attention is drawn to the fact that copyright of this thesis rests with the author. A copy of this thesis has been supplied on condition that anyone who consults it is understood to recognise that its copyright rests with the author and that they must not copy it or use material from it except as permitted by law or with the consent of the author.

Table of Contents

Acknowledgements	p4
Abstract	p5
Chapter one – introduction	p6
Chapter two – literature review	p10
- History of specialisation	p14
- Generalist versus specialist roles	p20
- The small community context - the challenges	p26
- Acculturation processes - the impact on recruitment and retention.	P33
Chapter three – research design	p42
- Aims, Objectives and Conceptual framework	p42
- Methodology	p45
Chapter four –the results	p63
- The participants	p63
- The research context	p64
- The final themes	p66
o Global policy and trends	
o Professional and regulatory requirements	
o Policy and legislation	
o Organisational Infrastructure	
o Individual context: Characteristics and background	
Chapter five – discussion	p105
Chapter six – conclusion	p126
Bibliography	p130
Appendices	p154
- Appendix one: Letter sent to long serving participants	p154
- Appendix two: Letter sent to New Employees	p155
- Appendix three: Information sheet	p156

- Appendix four: Consent form	p158
- Appendix five: Follow up letter	p161
- Appendix six Interview script (new recruits)	p162
- Appendix seven Interview script (experts)	p163
- Appendix eight – the complex relationship between the nodes	p164

Acknowledgements

I would like to take this opportunity to thank a number of people who have helped and supported me on this long journey. I would like to thank HSSD for providing the funding to support my studies, the participants who agreed to take part in the study, my colleagues at the Institute who have listened to my emerging ideas and cries of despair and my extended family who have had to tolerate my bouts of studying over the last 30 years. I would also like to thank Dr Alan Buckingham and Dr Sara Johnson, who have both supported me through this final phase of the Doctorate. I would like to thank my daughter Emily who has encouraged me to keep going when I threatened to throw in the towel. Finally I would like to thank my long suffering husband Andrew, who has taken on so much so I can complete my studies; I could not have finished this work without you.

Abstract

Introduction: The recruitment and retention of Registered Nurses (RNs) in Guernsey and Alderney has been a continual challenge over the years. Whilst measures have been put in place to address the problem, these solutions have had little sustained impact on the problem. The current vacancy rate is double that being experienced by National Health Service (NHS) Trusts outside of the London area. This study proposed to explore the recruitment and retention problem in a more holistic way by capturing the experiences of RNs who are working within the Islands.

Study aim: To explore the professional and personal challenges facing generalist RNs working and living in two small island communities.

Methodology: An experience-centred narrative research methodology was used to explore the experiences of 20 newly appointed RNs and 15 long-serving RNs. The data consisted of 35 'stories' which were captured through the use of semi-structured interviews, written accounts and visual media. The data was analysed using a critical hermeneutic approach.

Results: Sixteen themes were identified and aligned with the conceptual framework underpinning the study. The stories of the participants were used to develop a model to demonstrate the acculturation process they were experiencing.

Conclusions: It was recognised that all new recruits undergo a process of acculturation when they take up employment in the Islands. The study demonstrated that the process of acculturation was a continual journey and that the longer-serving participants were also undergoing a process of adjustment to the on-going cultural changes taking place in the organisation. The research highlighted that this acculturation process was influenced by multiple inter-connected factors which contributed to the challenges perceived by the participants. Whilst these factors had some commonality with those identified in the literature, the specific nature of the issues raised by the participants in this study were context dependent.

CHAPTER ONE

Introduction

Recruiting and retaining Registered Nurses (RNs) in Guernsey and Alderney has become increasingly challenging over the years. The annual turnover rate for staff employed from outside of the Island was 29% in 2008 (HSSD, 2010), which fared less well with the figures for England, which was 7.3% during 2006/7 (NHS, 2009). More recent figures (fig one) indicate that staff turnover reduced sharply in 2011, however 2012 saw turnover increase, especially for non-local nurses (HSSD, 2013).

Fig. one: Labour Turnover of Nursing staff within HSSD



Statistics for January 2016 indicate that the vacancy rate for RN posts within HSSD has risen to 21% (HSSD, 2016). Whilst this is comparable to the vacancy rates experienced by NHS Trusts based in London (Royal College of Nursing (RCN), 2015), it is twice the national average which is cited as 10% (Jones-Berry and Kleebauer, 2016). In addition, the turnover rate for all RNs both local and non-local during 2015 has risen to 21% (HSSD, 2016). In recent years recruitment drives have extended beyond the United Kingdom (UK) to Portugal and the Philippines. Evidently these measures have had little impact on the stability of the local workforce, resulting in the temporary closure of wards and the over-reliance on costly agency staff.

Although recruitment and retention problems within the healthcare setting cannot be attributed to one specific factor (Humphreys et al, 2009), it is recognised that the underserved or remote and rural context poses particular challenges for the recruitment and retention of healthcare professionals (Grobler et al, 2009). Since Guernsey and Alderney are geographically isolated from certain healthcare services they could be categorised as being 'under-served and remote'. This is especially true for Alderney which has a limited range of services on the island and relies on Guernsey and the UK to meet the shortfall in its provision. Consequently the recruitment and retention issues associated with these islands could be similar to those experienced in other underserved or remote and rural communities. Humphreys et al (2009) suggest that recruitment and retention of the healthcare workforce is affected by the complex interplay of a number of factors which are not just work related; personal and lifestyle factors also play a part. This proposition, which is based on an extensive review of the literature, highlighted that these factors are influenced by the socio-political and cultural changes which may be taking place within society at any given time.

Guernsey has a population of 63,000 and is categorised as being 'too small' to meet the national standard for providing emergency surgical services, which the Royal College of Surgeons of England (RCSE, 2006), set as 300,000. Despite this, Guernsey still has an emergency surgical service and, over the years, has expanded its provision of health and social care to the point where the breadth of services compares favourably with most UK district general hospitals serving much larger populations (HSSD, 2011). This has created a paradox, where the community has good access to services but there is a limited number of staff to deliver them. This has impact on the way the workload is organised; the usual division of labour into specialised units, as seen in large urban trusts, is not sustainable in a smaller setting (Bushy, 2000).

RNs employed in small community settings are expected to provide care for people with a greater range of needs, regardless of their field of expertise. As a consequence they experience an increase in role 'breadth', especially for those working as 'generalists' (Bushy, 2006). Rosenthal (2005) in her study of nursing stories of 'going rural' recognised the need for rural nurses to work as a 'jack of all trades'. She highlighted that nurses who have previously worked in urban settings experienced a

feeling of moving from expert to novice when they took up post in a smaller community context. This is true for RNs choosing to work in Alderney where they will be expected to work in both a hospital and community setting and to a lesser extent in Guernsey where they may be working in their preferred field of practice but are faced with a very wide spectrum of client need. RNs working in these small communities are by necessity functioning as generalists but are challenged by the fact that the healthcare 'world' is becoming increasingly specialised.

Humphreys et al's (2009) theory also highlights the importance of considering the personal and lifestyle factors which may impact on the recruitment and retention of staff. Rosenthal's (2005) research, although limited to the stories of 8 RNs working in a mountain town, highlighted the challenges they faced with living as well as working in a small community. Role conflict, lack of anonymity, and professional isolation were some of the themes which arose from these narratives. RNs employed in Guernsey and Alderney will be working and living in an environment where there is a high probability that people will know each other, and as such the themes highlighted in Rosenthal's work may have some transferability to these settings. In addition, Rosenthal (2005) highlighted that RNs often felt that they were an outsider until they had been a community member for a long period of time and had made an effort to become involved in community life. Rosenthal's work suggests that these RNs are initially perceived as 'outsiders' by members of the community but over time they gradually become accepted as an 'insider'. It is argued that when RNs move to these small communities they undergo a process of acculturation which results in the individual adapting psychologically and socio-culturally to their new environment in order to 'fit in' (Sam, 2006). Since Guernsey and Alderney employ RNs from all parts of the Globe, it is likely that this acculturation process could be very challenging for some especially if their first language is not English (Masgoret and Ward, 2006).

This initial analysis of why Guernsey and Alderney are facing recruitment and retention problems has highlighted three key areas. The first is connected to the challenge of working as a generalist in a healthcare world which is becoming increasingly specialised. The second is related to working as a registered healthcare professional in a small island community and the third is associated with the psychological and

socio-cultural adjustments that individuals have to make to fit in with island life. Existing literature related to these key areas are critically reviewed in the next chapter.

CHAPTER TWO

Literature review

This chapter provides details of the literature review underpinning the research study. The search strategy used to identify the literature is critically evaluated in terms of its ability to identify the relevant literature. The selected literature is then reviewed in relation to its quality and contribution to a theoretical framework to support the study and shape its focus. Finally the aims and objectives of the study are detailed at the end of the chapter.

PICO methodology was used to define the key areas of research interest. This resulted in the development of two broad questions:

- 1) 'What is the role of the health and social care professional working as a generalist in a small community?'
- 2) 'What is the impact of the acculturation process on the recruitment and retention of health and social care professionals from other countries?'

The questions were broken down into the four PICO elements to identify the searchable terms in the form of key words (tables one and two). A simple search of the literature indicated that generalist roles were often compared with specialist roles, so a decision was made to include special/ist/ism as the comparison in table one. Both tables provide details of the databases that were included in the search strategy and the specific key words and search terms that were used for each database.

Table one: Using a PICO to identify key words and terms for question 1.

PICO	Population	Intervention	Comparison	Outcome
Breakdown of search question	Health and social care professionals	generalist	specialist	Role in small communities
Keywords	Each discipline could be inputted individually to gain more specific results	Generalist, generalism	Specialist specialism	Role Small communities
CINAHL headings and MEDline MeSH terms	The subject headings and MeSH terms were discipline specific and could be used for more focussed searching.	No relevant heading for CINAHL but recognised as a keyword MEDline suggest family physician, but too narrow for the purpose of this search	The subject headings and MeSH terms were discipline specific and could be used for more focussed searching.	Role is recognised as a major subject heading and Mesh term Small communities are known as 'rural' for both MeSH terms and CINAHL headings
SOC index	As above	Subject terms could be used to narrow focus, but recognised as key words	Subject terms could be used to narrow focus, but recognised as key words	Subject terms could be used to narrow focus, but rural and role recognised as key words
EMBASE Web of science Zetoc BNI ProQuest Nursing and allied health source	As above	Recognised as key words but results are not always specific to my area of interest	Recognised as key words but results are not always specific to my area of interest	These are recognised as key words but results are not always specific to my area of interest
PsycEXTRA - thesaurus PsycINFO -thesaurus	As above	No suggested alternative terms in thesaurus but recognised as keywords	No suggested alternative terms in thesaurus but recognised as keywords	No suggested alternative terms in thesaurus but role and rural recognised as keywords

Table two: Using a PICO to identify key words and terms for question 2.

PICO	Population	Intervention	Comparison	Outcome
Breakdown of search question	Health and social care professionals from other countries	Impact of acculturation		Recruitment and retention
Keywords	Each discipline could be inputted individually to gain more specific results	Acculturation Assimilation Socialisation Adaptation/adapt		Recruitment Employment Retention
CINAHL headings and MEDline MeSH terms	The subject headings and MeSH terms were discipline specific and could be used for more focussed searching.	Acculturation is both a subject heading in CINAHL and a MeSH term in MEDline, the other synonyms have alternative meanings and need to be used with care		Personnel recruitment, personnel retention and employment are all subject headings in CINAHL Personnel selection and employment is a MeSH term in MEDline
SOC index	As above	Acculturation is a recognised subject term, with the synonyms as related terms		No relevant subject headings
EMBASE Web of science Zetoc BNI ProQuest Nursing and allied health source	As above	These are recognised as key words but results are not always specific to my area of interest		These are recognised as key words but results are not always specific to my area of interest
PsycEXTRA - thesaurus PsycINFO -thesaurus	As above	Acculturation is a recognised search term and should be used instead of assimilation. Socialisation and adaptation are also recognised terms but need to be used with care.		Personnel recruitment is the recognised search term for these key words.

Ten databases were selected to cover a wide range of journals, conference proceedings, grey literature and citations related to health and social care. Where available, the database thesaurus or subject-heading tool was used to find alternative terms for the keywords identified. The following keywords and search terms were used to search the databases: generalist/ism, specialist/ism, rural, role, acculturation, personnel recruitment, personnel retention, recruitment, retention. Boolean logic was used to combine these terms to obtain the literature most relevant to the two questions cited above.

These search terms were also used to search Google Scholar and the websites of the following organisations:

- The World Health Organisation – global perspective
- Queensland Government (Health/Rural and remote) – international perspective
- The Department of Health/NHS sites of the four countries - national perspective
- The Royal Colleges - professional perspective
- The States of Guernsey Government sites - local perspective

Relevant texts were obtained from the local library and the British Library by searching the related catalogues. Additional sources were obtained from reference lists and by scanning the contents page of relevant Journals.

This was not an exhaustive search of available literature, although the search strategy did achieve the goal in 'casting a wide net' to capture a representative perspective of the current literature related to the areas of interest. Fink (2005) does warn that an over-reliance on databases and other electronic sources can result in a search strategy which obtains only published material and excludes literature which does not include the 'expected keywords'. Despite this obvious disadvantage, the search strategy generated a very large volume of literature which was managed by imposing the following inclusion and exclusion criteria:

- 1) All papers were peer reviewed prior to publication
- 2) All papers were published after 1990
- 3) All papers were published in English
- 4) All papers deemed to be relevant following a critical read

This generated a total of 165 papers: 137 research papers, 7 systematic/critical reviews, 15 polemic articles, 2 narrative/vignettes, and 4 theory papers. Additional policy papers, standards and guidelines were obtained from the professional and political web sites including 3 from international sites, 22 from national sites and 9 from local sites. The search of the library catalogues resulted in 19 relevant texts being identified.

The following review will provide a critical evaluation of the literature related to the following areas. The first part of the review will explore the impact that the specialisation of health services has had on the 'generalist role'. This will include a historical account of how health services have evolved over the last century and how this has influenced the development of specialist and generalist roles especially those related to nursing and medicine. The main themes arising from the specialist/generalist debate will then be analysed to establish the key challenges facing the 'generalist' practicing within a healthcare context which is becoming increasingly specialised. The second part of the review will focus on the role of the health/social care professional working within small/underserved/remote and rural communities. This section will also consider some of the challenges that healthcare professionals may face when they both live and work in these particular contexts. The final section will explore theory related to acculturation and the part this process plays in the recruitment and retention of staff from other countries. Following a brief synopsis of the review, a defined area worthy of further enquiry will be discussed and justified, concluding with a research aim and key objectives.

History of specialisation

According to Weisz (2006) historical artefacts indicate that there was some form of medical specialisation as far back as the ancient Egyptians, however medical specialisation did not reach the Western world until the 19th century. He goes on to argue that specialisation occurred as a result of surgery and medicine becoming a unified profession as this brought them together in 'Institutions of training and research'. He contends that it was the need to develop different fields of knowledge through research in these Institutions, which led to the emergence of the different medical specialisms. Abbott (1988) provides a useful theoretical perspective on this

move to specialise. He suggests that as the jurisdiction of a profession extends it becomes increasingly vulnerable to 'specialisation' as 'no profession can extend its jurisdiction infinitely' (p.88). Therefore as new medical knowledge emerged and stretched the professional boundary, the pressure to specialise resulted in the developments described by Weisz (2006).

Stevens (1966) believes that the greatest impetus for medical specialisation in England was due to 20th Century technology which resulted in medical care shifting from a generalist with special interest model to one where hospital-based practitioners were practicing full time in one specialism. These individuals were recognised for their specialist skills and training as well as their ability to provide more efficient and effective care. The inception of the NHS in 1948 provided an infrastructure, which further supported the specialisation of medicine; with hospitals delivering specialist services, leaving the 'generalist' practitioner to provide more community based care. This 'division of labour' is considered by Durkheim ([1893]1984) to be 'one of the fundamental bases of the social order' (p.3), perceiving it to be a natural development which takes place as societies advance and evolve. He goes on to suggest that this process occurs within professional groups because over time the expansion of their territory results in the individual professional being unable to 'encompass the whole field'. Watson (1995) distinguishes this technical division of labour from a social one, in that the latter results in the formation of certain occupational groups whilst the former considers the allocation of tasks within the occupation itself. In addition Adam Smith (1776 cited in Durkheim, [1893]1984) in his analysis of the work undertaken by pin makers, argues that the division of labour is necessary for the development of the 'expertise' required for efficient output and increased productivity. This supports Stevens' (1966) conjecture concerning the benefits of specialist practice in the provision of efficient and effective care.

Rivett (2016) provides another perspective by suggesting that the specialisation of hospital services in the NHS was not just driven by the advancement of technology but came from a growing body of evidence that some patient outcomes were 'dependent on the size and facilities of the Institution' treating them. This led to larger hospitals being built in the 80s and 90s serving populations in advance of one million. It was mooted that general hospitals serving populations of <500,000 were no longer

viable. These smaller general hospitals could not accommodate the specialisation of services as easily as their larger counterparts. In addition they were less able to provide emergency care as consultants were now very specialised and lacked the broader generalist skills to provide emergency cover in smaller institutions; this had impact on the provision of services in remote and rural settings (NHS, 2013). The rise of managerialism within the NHS during these decades was a strong influencing factor in the move to provide services which were efficient and effective with an emphasis on evidence based practice (Traynor, 2013). Furthermore, the political will to modernise the NHS through the development of national standards and the introduction of governance infrastructures in the late 90s, provided a mechanism to measure organisational performance against specific targets. Whilst the intention was to improve the quality of service provision through these processes, the standards being set did not take into account: The economies of scale experienced by remote and rural contexts; the broader remit of staff working in small organisations; and the inability to provide specialist services in the same way as larger centres (NHS Scotland, 2005). The implications this had for practitioners working in remote and rural settings will be considered in more detail later on in this review.

So far the review has primarily focussed on the impact of specialisation on the medical professional and the development of the NHS in the UK, especially in relation to the delivery of secondary care in hospitals. This next section will focus on the implications of the specialisation agenda for nursing and its quest to be recognised as a profession in its own right. Maggs (1983) in his account of the origins of the General Nurse, suggests that the growth of general and specialist hospitals from 1880s onwards, required a greater number of nurses to staff them. The new General Nurse which emerged, was technically trained, which resulted in the reduction of hospital mortality rates and length of stay. In addition, the general nurse of the early 20th century enjoyed a higher standard of training than their counterparts based in specialist hospitals.

This situation was short-lived as the development of the NHS in 1948 began to see the growth of specialist hospital services (Rivett, 2016) and with it a demand from the medical profession for specialist nurses who had the expertise to care for their patients. Both Freidson (2001) and Abbott (1988) recognise this apparent super-

ordinate position of medicine in relation to nursing which resulted in the imposition of new professional boundaries for nursing. By creating these new roles, it could be argued that medical staff were able to delegate 'routine work' through a process of 'degradation' (Abbott, 1988) whereby certain tasks are no longer viewed as requiring the skills of a medical professional. Paradoxically, this de-skilling of these tasks was not the perception of specialist nurses. Whilst the generalist nurse was seeking material rewards for the work they did, specialist nurses were insisting on better standards of education in their quest for higher professional status and authority. They were also better able to develop knowledge within their specific fields of practice (While, 2005). The developmental path of the specialist nurses links with the traditional perspective of professionalisation whereby the occupation carves out an 'exclusive jurisdiction' in terms of knowledge and skill and sets specific standards of education and training for those wishing to join the occupation (Wilensky, 1964).

It could be argued that specialisation brought with it the opportunity for specialist nurses to be recognised as professionals and as such they were able to command higher salaries than their generalist counterparts (White, 1985). However, whilst the specialist nurse had gained greater kudos, this was possibly due to their partial migration into the territory of the superiorly positioned and more powerful profession of medicine (Abbott 1988); medicine permitted the migration of nursing into its jurisdiction but maintained control of the professional boundary.

The new Millennium saw the introduction of the European Working Time Directives which impacted on the number of hours that junior doctors were permitted to spend on duty. This evidently created a gap in service provision which Rivett (2016) perceived as a key driver in the development of the nurse consultant role. The surplus of 'junior doctor work' created an opportunity for specialist nurses to extend further into the medical jurisdiction. Rivett's account does suggest that the emergence of the consultant role was driven by the organisation's need to re-negotiate professional boundaries to ensure that service obligations were met (Abbot, 1988); rather than an attempt by nursing to use a 'forceful inclusionary strategy' to move their professional boundary further into medical territory (Witz, 1992 cited in Macdonald, 1995). Whilst the specialisation of nursing appears to be synonymous with its quest for

professionalization, it is evident that the processes involved were controlled by two powerful bodies outside of the occupation, Medicine and the Health Service Managers.

There is a lack of statistical data indicating how the opportunity to specialise impacted on the proportion of the nursing workforce choosing to take this career path. The RCN in 2013 identified nearly 55,000 RNs with a specialist practice qualification on the NMC register, accounting for less than 10% of all NMC Registrants. In view of the perceived kudos associated with specialist practice, it is surprising that this figure is so low. The fact that the title of Specialist is not protected and does not need to be recorded on the Register may have resulted in an underestimation of the true number of nurses working in specialist roles. In addition, as a result of attempting to cut costs, organisations have chosen to down-grade or not fully utilise the nurse specialist role, resulting in a negative impact on the number of people employed in these positions (RCN, 2013).

The review so far provides some insight into the specialisation of nursing and how this helped to drive the professionalization process of the occupation. However, the 80s and 90s saw a fundamental shift in the way nurse education was delivered in the UK. The model moved from an apprenticeship style approach based in schools of nursing, to a commitment to produce RNs who had been exposed to the benefits of Higher Education. This 'knowledgeable doer' would have the cognitive and technical skills fit for the complexity of care delivery in the 21st century (Traynor, 2013). It also ensured that all RNs were equipped with a Higher Education qualification at the point of registration, regardless of whether they went on to specialise or not. In addition the occupation was well placed to develop the unique body of knowledge required for professional status by being positioned in Institutions where research activity was an expectation. Whilst this move into higher education should have been a catalyst in the professionalization process for nursing as a whole, there is still some debate as to the exact jurisdictional boundaries which define nursing as a profession.

Law and Aranda (2010) suggest that the emergence of the Associate Practitioner role has re-energised the debate as to what elements of the traditional nursing role have been de-professionalised and which aspects remain within the domain of the RN. The desire for RNs to achieve professional recognition through specialisation and the

expansion of their role into the medical domain has resulted in the erosion of 'routine work' which could be considered to be core to the nursing role (While, 2005). Abbott (1988) states that the jurisdictional claims made by professionals may change as a result of organisational demands as demonstrated here. He also argues that a profession which is 'widely spread' may 'lose strength' within its current boundaries if it takes on additional responsibilities. This could also contribute to the perception that specialist nurses have more power than generalist ones as the scope of their role is likely to be narrower and therefore easier to maintain control over.

The line of debate in this review suggests that RNs need to specialise in order to achieve the professional recognition they seek. However, Durkheim ([1893]1984) does highlight that whilst the 'rule of the division of labour' is such that it promotes specialisation, there is a danger that this will be done 'to excess'. He suggests that this evolutionary direction is at odds with the 'duty to become a rounded complete creature, a whole sufficient unto itself' (p3). It can be argued that this 'rounded complete creature' can be found in the guise of the Generalist Practitioner who is 'capable of being interested in everything but attaching himself exclusively to nothing' (p4). While (2005), suggests that the propensity for specialisation can result in the fragmentation of care as the input from specialist nurses is 'episodic' in nature. She goes on to propose that the generic nurse provides a co-ordinating function that is broad and flexible and as a consequence more closely fits with the delivery of holistic nursing care. The specialist generalist debate is not a new one and will be considered in more detail in the next section of the review.

This brief historical account has demonstrated how the specialisation of health services has had impact on the way that specialist and generalist roles have evolved and developed within both medicine and nursing in Great Britain. Although this historical review is limited to one nation, it captures the complex interplay of the professional and organisational processes which determine the jurisdictions of the key players involved in healthcare delivery. The next section of the review will critically evaluate the research literature comparing specialist and generalist roles within the fields of health and social care.

Generalist versus specialist roles

Generalist and specialist roles; the jurisdictional challenges

The jurisdictional challenges facing both the generalist and specialist are related to the scope of their role and the way in which this is determined and managed. Generalists are faced with the tension of managing a wide scope of practice within a context where the trend is to specialise; the dramatic increase in available knowledge and the move to evidence based practice has made 'it impossible to sustain such a wide scope...' (Beaulieu et al, 2008, p1158; McKenna et al, 2003). However the role of the generalist continues to expand despite the evident difficulties being experienced. A number of the studies reviewed highlight that the field of palliative care is increasingly falling within the domain of the General Practitioner (GP) working in the community (McKenzie et al, 2007; Shipman et al, 2008; Gardiner et al, 2012; Carr et al, 2005; Gott et al, 2011). In addition 16% of the contacts that GPs had with patients were for problems associated with other presenting diseases; these included 'depression, hypertension and drug dependency' (Dorr et al, 2005, p1411). Furthermore, GPs admitted to having a general lack of confidence and competence in diagnosing, treating, screening and assessing people with dementia (Manthorpe et al, 2003). Other papers do indicate that this feeling of inadequacy is not confined to generalists working in community settings. A survey of newly qualified Generalist Paediatricians, felt 'unprepared' to provide medical care in areas such as mental health, sports medicine, and oral health (Freed 2009). These findings are further supported by other studies focussing on the generalist role within care settings outside of the 'community' (Card et al, 2006, Ramritu et al, 2002, Siminerio et al, 2007).

Despite the evident 'far-reaching' remit of the generalist role, GPs often feel undervalued, with a lack of recognition for the role they play in care delivery especially from the hospital based specialists (Schroeder, 2002; Beulieu et al, 2008; Crossley and Lepping, 2009; Natanzon et al, 2010). This perception demonstrates the existence of a paradox, where a well-established and powerful profession such as medicine contains power differentials as a result of the technical division of labour amongst its subgroups. Abbot (1988) suggests that this internal stratification arises in relation to the degree to which the professional is exposed to front-line work. Whilst specialists are able to regress into a purely medical field as they become more expert, GPs

remain at the 'front-line' where the content of the work is influenced by the messy and complex needs of the client and as such does not receive the same professional acclaim. As a consequence, Beaulieu et al, (2008) found that even those Family Practitioners who were 'comfortable' with 'non-expert' status were compelled to specialise in something to gain kudos within an increasing specialist culture.

Specialist interest roles do have appeal and could potentially improve recruitment and retention of doctors within primary care and go some way to address the current recruitment issues experienced in the UK (Boggis and Cornford 2007). The Royal College of General Practitioners (RCGP) have embraced this move to develop specialist interest roles through the development of competency frameworks (RCGP, 2013). However, Currie et al, (2009) highlights that in reality the implementation of special interest roles is far from unproblematic. Their study examined the negotiation processes involved in the implementation of the role of the GP with a specialist interest (GPwSI) in genetics. One of the four points in their concluding comments was that the adoption of GPwSI could 'undermine' and erode the 'coherent identity' which underpins the traditional GP role and in so doing weaken, the professional position of this group rather than strengthening it.

Currie et al's (2009) study also revealed the complexity surrounding the interface between the GPwSI in genetics and the Specialist Geneticists based in regional centres. It was clear from their findings that the Specialists held a position of power over the GPwSI by virtue of their established recognition as 'the expert' and the fact that the GPwSI was dependent on them for training, development and support. These apparent tensions around the generalist specialist interface are well reported in the literature reviewed. Gott et al's (2011) qualitative study of the management of palliative care in England and New Zealand revealed that there was 'a bit of a power struggle' (p236) between specialist and generalists, especially within the New Zealand context. Furthermore Gardiner et al, (2012) in their systematic review of the literature examining the working relationship between specialist and generalist palliative care services identified 'professional territorialism' as being a barrier to good working relationships. They go on to state that this territorialism can result in 'power issues' and 'deskilling' of the generalist role.

The issue of the de-skilling of the generalist role was also highlighted in Jack et al's study (2004) which explored the perceptions of third year student nurses around the impact of the clinical nurse specialist role. This survey went on to highlight three processes involved in the deskilling of Generalist Nurses by their specialist counterparts in their quest to secure occupational closure. One process involves the specialist 'taking over' from the generalist's area of 'specialist interest' thereby preventing them developing their knowledge base and fostering a relationship of dependency. Witz (1992, cited in Macdonald, 1995), would consider this process to be an 'exclusionary strategy', used to protect the jurisdiction of the specialist. The second process is connected to the potential conflict which can emerge between the two roles leading to communication difficulties. This reflects the power struggle between the two groups, with the specialists forcing 'exclusion' of the generalists and the generalists making attempts to 'usurp' the specialists (Witz, 1992 cited in Macdonald, 1995).

The third process is associated with the lack of clarity in the boundaries existing between the two roles resulting in role confusion. This possibly indicates that, whilst the specialists are in a position of power over the generalists they have yet to achieve 'demarcationary closure' in terms of their occupational role. It could be argued that the absence of an agreed regulatory framework for specialist practice (Dury et al, 2014) has contributed to the lack of occupational closure around the role of the specialist nurse. The role remains unprotected in law, thereby denying this professional group the 'legal monopoly' of their practice which Larkin (1983 cited in Macdonald, 1995) views as a requirement for social closure. This leaves the boundary between the two groups in an ambiguous position with the role of the specialist being vulnerable to usurpation by the generalist (Witz, 1992 cited in Macdonald, 1995). The studies reviewed here demonstrate that there is as much a powerful interplay over professional boundaries within the professions as there are between them.

Despite the apparent status of specialists in relation to generalists, the role is not without problems. McKenna et al, (2003) warns of the potential problem of patients falling 'between the cracks' (p541) if there is an over emphasis on the specialist role. These cracks emerge due to a lack of clarity where one specialist role ends and another begins. Blom (2004), also highlighted difficulties with specialist roles, he

suggests that 'the division of functions' which comes with specialist practice doesn't always match 'the complexity of clients' life-situations'(p36). His findings go on to highlight the dissatisfaction that some specialists felt in not being able to form relationships with their clients as the type of contact they had with them had become formal and superficial. Manca et al, (2011) concur with these findings by stating that specialist care can be reductionist due to it being focussed on disease rather than the needs of the patient as a whole. These findings further support Durkheim's ([1893]1984) theory which warned of the dangers of over specialising and being 'only part of the whole'.

This section of the literature review has provided an overview of the tensions and challenges which exist between specialist and generalists roles within the health and social care context. Specialists appear to hold a super-ordinate position in relation to the generalist and as such have the power to manage jurisdictional boundaries. However this is countered by the limitations that come with having such a narrow focus and remit. The next section will examine more closely the literature related to the output of each role in terms of the degree to which they can contribute to the provision of quality care.

Quality of care: Who is best?

As highlighted earlier, one of the main drivers supporting the specialisation of services is related to the need to provide quality care which is both efficient and effective. This implies that specialist care is considered to be superior in terms of its outcomes when compared with the care provided by generalists. This notion is supported by a number of the studies reviewed (Maclean et al, 2000, Barclay et al, 2002 and Brevetti et al, 2007) and was attributed to the greater bank of knowledge and expertise held by the specialists (Maclean et al, 2000), the perceived gaps in the knowledge base of the generalists when faced with the less common scenario (Barclay et al, 2002) and the specialists using more pharmacological treatments and ordering more diagnostic procedures than the generalist counterparts (Brevetti et al, 2007).

A systematic review (Smetana, 2007) evaluating studies 'comparing outcomes resulting from generalist versus specialist care for a single medical condition', found

that 24 of the 49 studies reviewed favoured specialist care. However, it should be noted that 13 of the studies found no difference in outcome between the two groups and 4 favoured generalist care. Another systematic review conducted by Post et al, (2009) addressed the question, 'Do specialized centres and specialists produce better outcomes for patients with chronic diseases than primary care generalists?' The review included 22 different studies which were mostly of poor quality with inconsistent findings. The authors concluded that specialist care for patients with rheumatoid arthritis, diabetes mellitus and cystic fibrosis was not superior to other forms of care. Furthermore a polemic article by Schroeder (2002) suggests that 'some intriguing new data' indicates that the 'intensively technology-orientated approach' (p771) associated with specialist practice results in poorer outcomes. Although Schroeder fails to support this position with referenced literature, a study by Ledwidge et al, (2004) suggest that specialist practice is likely to result in an increase in the use of pharmaceutical treatments in line with the evidence base. This can lead to polypharmacy and a subsequent risk of drug-interactions taking place. Ledwidge et al, (2004) do highlight, however, that specialist intervention did, on the whole, result in better quality prescribing practices.

The literature examined above appears to favour specialist care in terms of patient outcome, especially with respect to mortality rates and prescribing habits. Nevertheless, the literature does indicate that there is support for the generalist role within the healthcare team. Beaulieu et al,'s (2008) study alluded to earlier, presents the family physician as a 'complete' being who's 'scope of practice precedes, explains, and creates continuity, integration, and trust' (p1161). They go on to state that 'without this scope of practice, the chain is broken' (p1161). The generalist is therefore seen as a care co-ordinator who is the one constant in the patient's journey through the healthcare system. This notion is further supported by Burt et al, (2008) in their study exploring the palliative care role of community nurses (CNs) within the context of their generalist workload. The authors concluded that the CNs were the 'cornerstone' in the provision of palliative care in the home, and in so doing provided a co-ordinating function in the care of this client group. This position is acknowledged in two polemic articles considering the challenges which generalists will be facing in the future. Crossley and Lepping (2009) refer to the 'central perspective' of the generalist which provides them with 'oversight' of patient care; whilst Harris and Harris (2006) use the

terms 'comprehensive', 'continuous' and 'co-ordinated' to describe the role of the generalist in the delivery of primary care.

The literature suggests that there is a place for both specialist and generalist roles within the context of health and social care. Indeed some studies have demonstrated that a collaborative approach between specialist and generalist practitioners can result in the best use of resources and better outcomes of care. A study by Lowe et al, (2000) evaluated an admission policy that selectively refers patients with cardiac failure to either generalists or specialists according to specified criteria. The findings indicated that the implementation of the policy permitted best use of the skills available without compromising care outcomes. Moreover a study by Ahmed et al, (2003) found that collaboration between generalists and cardiologists resulted in better care outcomes for people with heart failure than 'solo care' delivered by either role. This collaborative approach is further supported by Beaulieu et al, (2008); Freed et al, (2009); Gardiner et al, (2012); Gott et al, (2011); Manca et al, (2011) and Stille et al, (2005). Although there is good support for this collaborative approach the jurisdictional challenges highlighted in the previous section cannot be ignored as these are likely to affect the ability of the team to work as a collective whole. Stille et al, (2005) in their study of the generalist's role in the co-ordination of care, discuss the importance of the 'team' having defined roles, and the importance of both specialists and generalists being educated in the skills of communication and collaborative team working.

This section of the review highlights the strengths associated with both specialists and generalist roles. The literature indicates that the broad-based co-ordinating function of the generalist can complement the narrow but in-depth expertise of the specialist. In Durkheim's ([1893]1984) view, the collaboration of the two roles would re-unite the diverging paths of the generalist and specialist, each capitalising on the strengths of the other in the quest to provide excellent care. However the implementation of such a model is not without its difficulties, not least in respect of the jurisdictional issues associated with these roles. The next section of the review will continue to build on the issues and concepts presented so far in considering the role of the health/social care professional working within small/remote and rural and underserved communities. This section will also explore some of the challenges that healthcare professionals may face when they both live and work in these particular contexts.

The small community context - the challenges

Establishing a definition - what is a small community?

Identifying literature related to the delivery of health and social care in small communities is challenging. Firstly there is a lack of a clear and consistent operational definition of what constitutes a 'small community' and secondly there are a number of alternative terms used in the literature to denote these type of contexts. 'Small community' is frequently linked to the term 'remote' (Battye and McTaggart, 2003; Campbell et al, 2012), 'Frontier' is a term used to categorise communities with a population of less than 6 people per square mile (Bushy 2000) and Grobler et al, (2009) in their systematic review identified 'underserved' as another term to add to the list. They went on to state that an 'internationally agreed' definition of 'rural underserved' or 'urban underserved' did not exist and concluded that definitions vary between countries.

Campbell et al, (2012) adopted a 'common-sense' approach to their description of rural and remote by suggesting that rural and remote communities are those which sit 'beyond major metropolitan areas' (p3). Other authors attempt to define the terms more precisely by specifying a particular population size or density. For example, Helbok (2003) considers a rural community as having a population of less than 5,000 whereas Kitto et al, (2011) set this figure at less than 80,000 and Montour et al, (2009) at less than 100,000. Battye and McTaggart, (2003) undertook a study in remote north-west Queensland which had a population density of 0.03-0.55 persons/Km² whilst Bushy (2000) would consider a population density of less than 98 but more than 6 people per square mile as being the determinant for a rural community. Clearly there is a lack of agreement in the literature as to what a 'small, remote and rural or underserved' community may 'look like'. Although this lack of consensus relates to the fact that these community contexts are diverse, Bushy (2000) warns that this inability to agree on an operational definition will make it difficult to develop a body of knowledge for rural practice. Paliadelis et al, (2012) makes an attempt to provide a unifying definition of 'rurality':

'it reflects smaller populations, and distance and isolation from major centres with a corresponding lack of access to the full range of services and infrastructure' (p2).

This qualitative definition has a sense of fit with the context within which the proposed study will be taking place and will therefore be used to define small community for the purposes of this study.

Challenges of working and living in small communities

Francis and Mills (2011); Helbok (2003); Leipert and Anderson (2012) and Rosenthal (2005) acknowledge the generalist nature of the work health and social care professionals undertake within the small community context. Practitioners working in these settings are likely to be more acutely aware of the challenges of being a generalist especially with respect to their scope of practice. The division of labour varies widely from one context to another. Rosenthal (2005) provides a powerful image of the rural nurse delivering pre, intra and post-operative care to the same patient, whilst Drury et al, (2005) demonstrate how roles extend beyond their occupational boundaries into the jurisdiction of different professional groups. One of the community mental health nurses included in their study described themselves as a 'part-time social worker, counsellor, friend and nurse' (p23). Whereas Yates et al, (2012) conducted a study with individuals who more formally undertook dual roles in the form of midwife and nurse in rural Queensland. Vukic and Keddy (2002) also recognise this expansion of roles especially into the medical domain, however they do state that 'provincial licensing' of nursing practice does not recognise this extension of the nursing role, leaving the practitioner concerned unsupported by their regulatory framework. This position is further strengthened by Drury et al, (2005); Helbok (2003); Keane et al, (2012); Malone (2012); Mills et al, (2011) and Weiss Roberts et al, (1999) who recognise the wide scope of practice and the concerns this brings with respect to role boundaries and competence. However it is a paradox that this role breadth and the professional isolation experienced by the participants in these studies brings with it the autonomy and variety that attracts practitioners to rural environments in the first place (Leipert and Anderson; 2012, Nayda and Cheri, 2008).

Despite the challenging nature of the roles held by rural practitioners, there is a lack of status and due regard for these 'multi-skilled generalists' by their counterparts employed in more urban, metropolitan areas (Drury et al, 2005; Mills et al, 2007; Paliadelis et al, 2012; Campbell et al, 2012). This is further supported by the apparent

desire for newly qualified practitioners to seek roles which foster the development of specialist skills associated with the delivery of care in larger urban centres (Wilson 2007). However some rural generalists would argue that they have a set of unique skills which would classify them as a specialist generalist, operating at an advanced level (Nayda and Cheri 2008; Wilson 2007). Others admit that they need additional educational development to 'upgrade' their nursing skills (Bushy 2000). Individuals recruited from urban environments may experience a transition from being an expert to novice when taking up post in more rural settings, (Rosenthal 2005). This is further compounded by the unpredictable and complex nature of the rural setting (Nayda and Cheri 2008), the problems of accessing continuing professional development (Yates et al, 2012) and the lack of context specific research to develop an evidence base which 'fits' with the delivery of health and social care in these challenging environments (Kitto et al, 2011). Furthermore, whilst there is an expectation that rural settings will adopt similar standards and governance processes associated with metropolitan contexts, it is recognised that in some circumstances they may neither have the material or human resources to achieve these requirements (Paliadelis et al, 2012; Veitch et al, 2012; Wolstencroft and Macvicar 2011).

Other key challenges affecting practitioners working in small communities are those which may compromise the delivery of ethical practice. Weiss Roberts et al, (1999) uses a series of compelling vignettes to illustrate the daily ethical dilemmas facing rural care givers within the field of mental health. One issue was the multiple and overlapping roles that the practitioner will find themselves occupying especially as they integrate into the community setting (Weiss Roberts et al, 1999). Helbok (2003); Lee and Winters (2004); Malone (2012), and Paliadelis et al, (2012) also highlight this issue as being a problem across the delivery of health and social care and not just within the mental health context. Difficulties associated with maintaining confidentiality, working outside role boundaries and managing information about community members which may cloud professional judgement are also recognised within the literature (Helbok 2003, Lee and Winters 2004; Malone 2012, Weiss Robert 1999 and Paliadelis et al, 2012).

Another challenge is associated with the visibility of the practitioner within the community and the pressure this brings in maintaining their professional reputation.

For example Helbok (2003) highlights that a client living in a small community may know a great deal about their psychologist before they have had their first session together. This places a great deal of pressure on the psychologist in terms of presenting themselves as a good role model in the community. Iverson et al, (2002) recognises how the visibility of rural GPs make it difficult for them to escape their professional role, whilst Paliadelis et al, (2012) and Rosenthal (2005, p43) describe the role conflict experienced by practitioners working in small towns where 'everyone knows everyone's name'.

Despite these ethical challenges the literature indicates that practitioners working in small communities feel a sense of connectedness with the community members which helps to support their practice (Leipert and Anderson 2012). This is illustrated in a study by Vukic and Keddy (2002) which explores the experiences of nurses working in Northern Canada. The findings emphasised the importance of the nurse becoming involved in the community to avoid being perceived as an 'outsider' or the 'other'. Nurses in the study stated that if they were seen as an outsider then their ability to instigate any community health initiatives would be hampered. Malone (2012) builds on this perspective further by stating that this connection is essential for the development of trust between the practitioner and the community member especially within aboriginal communities. This is supported in a more recent study by Mills et al, (2010) which discusses the importance of the rural practitioner having a good understanding of the context in which they are working in order to develop clients' trust. They go on to state that resident rural nurses need to pass on this contextual intelligence to visiting practitioners who may be unfamiliar with the nuances of the small community. Iverson (2002) highlights how rural GPs feel 'a strong sense of responsibility, almost a 'tie' to the community' (p142). Although this may have its pressures, the findings of this qualitative study do describe the respect and value that community members have for their GPs which 'mitigates' against the less positive aspects of this close relationship. Moreover, Mills et al, (2007) suggest that the sense of community is a real attraction for some nurses especially if they have grown up in a small community; this attraction is enough 'to bring them home' (p586) from the larger urban centres. Unfortunately despite this attraction, the literature does indicate that the small community does have problems with both recruiting and retaining staff.

Recruitment and retention - issues and solutions

Humphreys's et al, (2009) provides some limited insight into the extent of the recruitment and retention problems experienced in rural and remote settings. Only 35 out of the original cohort of 108 primary care services provided length of service data, and of these just 20 services provided good quality information from which to draw a meaningful analysis. These data indicated that the annual turnover for doctors amounts to 11.5%, for nursing 13.8% and for allied professionals 30.5%. The data also indicated that rural locations had an annual turnover of 11.9% whereas locations considered to be remote as well as rural had a turnover of 23.2%. In addition the median length of service for nurses was 5.8 years, for doctors 3.4 years and for allied professionals 2.6 years. The median cost of replacing a nurse amounted to \$29,300, for a doctor, \$74,000 and for an allied professional \$21,925. Although it is difficult to draw conclusions from such a limited data set, the figures do indicate that there are problems with retaining staff in rural settings and that the replacement of staff is a costly venture regardless of professional background

A literature review of the factors affecting the recruitment and retention of allied health professionals amalgamates the findings from 35 small scale studies to capture the views of over 3000 allied health professionals (Campbell et al, 2012). The findings were predominantly generated through surveys and focus groups within the Australian context and highlighted that the intrinsic factors which motivate allied health professionals to work in rural settings are outweighed by the 'burden of extrinsic disincentives' (p12). They went on to conclude that this apparent imbalance contributes to the high turnover of allied health professionals which was identified in Humphreys et al,'s (2009) study cited above.

Some of the extrinsic disincentives identified in Campbell et al,'s (2012) review have been verified by other studies and include the following: lack of CPD opportunities and support from other professionals (Yates et al, 2012, Williams et al, 2007); lack of preparation for a role in rural practice (Vukic and Keddy 2002, Nayda and Cheri 2008); the cost and travelling time to attend courses and conferences (Williams et al, 2007); a heavy, diverse workload involving extensive travel (Veitch et al, 2012, Yates et al, 2012, Battye and McTaggart, 2003); the requirement to be regularly on-call (Patham

et al, 2004); lack of amenities, job opportunities for spouses and difficulties with housing (Keane et al, 2012); and the lack of resources, services and equipment (Paliadelis et al, 2012). Conversely the intrinsic motivators identified in the literature include: the sense of connectedness with the community (Yates et al, 2012; Mills et al, 2007; Keane et al, 2012; Helbok 2003); the challenge and diversity of the role (Williams et al, 2007; Paliadelis et al, 2012); the ability to develop client relationships (Birden and Wilson 2012); the autonomous nature of the role (Williams et al, 2007; RCPE 2005; Nayda and Cheri 2008; Helbok 2003); and the beauty of the environment with a low crime rate (RCPE, 2005; Lee and Winters 2004; Brooks et al, 2002).

This complex interplay of extrinsic and intrinsic factors contribute to the difficulties of developing robust recruitment and retention strategies. Humphreys et al, (2009) presented this as a schematic diagram which differentiated between factors which are modifiable and those that were not, thereby providing an analytical tool to assist with the development of workforce retention initiatives. Baker et al, (2012) have developed this concept further by producing the community Apgar questionnaire which can be used by community health centres to identify their 'communities' assets and capabilities' in relation to the recruitment of medical staff. Their study demonstrated that the tool was a valid and reliable instrument in that the score obtained with the questionnaire correlated with the historical workforce trends for the particular community being evaluated. They go on to suggest that the tool can help distinguish between modifiable and unmodifiable factors as well as assist strategists to identify those factors which should be addressed as a priority, channelling scarce resources into areas of greatest need. It should be noted however that these tools were developed within the Australian healthcare context in the first instance (Humphreys et al, 2009) and Idaho, USA in the second (Baker et al, 2012) which may restrict the external validity of these instruments.

The literature also evaluates the initiatives that have been used to promote the recruitment and retention of staff. One overwhelming theme that is linked with the recruitment of practitioners is the provision of a rural placement either during their initial pre-registration training programme or during their preceptorship 'rotation'. Brooks et al, (2002) demonstrate that longer rural rotations were likely to produce rural physicians, they deduced that this was due to the student being better prepared for

working in a rural context. This is further corroborated by Grobler et al,'s (2009) review, which identified the provision of under and postgraduate training in rural settings as being an influencing factor in medical students choosing a rural career pathway. Other studies supporting this correlation include Jones et al, (2009); RCPE (2005); Strasser et al, (2010) and Wolstencroft and Macvicar (2011). Moreover the literature indicates that access to formal education plays a key part in the recruitment and retention of other professional groups in the rural setting. These include the Allied Health Professionals (Battye and McTaggart, 2003; Keane et al, 2012), Community Mental Health Nurses (Drury et al, 2005), General Nurses (Mills et al, 2011, Francis and Mills 2010; Leipert and Anderson 2012, Montour et al, 2008), Midwives (Francis and Mills 2010), Occupational Therapists (McAuliffe and Barnett 2010) and Physiotherapists (Williams et al, 2007).

Other recruitment and retention initiatives that have been highlighted in the literature include: Assistance with accommodation, child care and spouse employment (Francis and Mills 2010); Formal induction and orientation of new staff both in their work role (Nayda and Cheri 2008; Montour 2008) and in their role as a community member (Brooks et al, 2002); Managerial approaches which provide emotional support and guidance as well as demonstrating a value for the employee as an individual (Keane et al, 2012; Williams et al, 2007). Veitch et al, (2012) and Williams et al, (2007) add financial incentives, flexible work arrangements and graduate scholarships to the list. Although these initiatives appear to be plausible in their intent to improve the workforce situation in rural settings, it is interesting to note that formal evaluation of the actual impact that these initiatives have on the recruitment and retention of staff appears to be absent. For example Montour et al, (2009) use words such as 'may' and 'might' assist staff retention and Williams et al, (2007) state that scholarships 'have the potential to improve recruitment' (p385).

One variable that is consistently linked with having a positive impact on the recruitment and retention of staff in the rural setting is the recruit having spent a considerable part of their up-bringing in a rural setting (Brooks et al, 2002; Grobler et al, 2009; Keane et al, 2012; McAuliffe and Barnett 2010; McGrail 2011; Patham 2004, Strasser et al, 2010; Williams et al, 2007; Wolstencroft and Macvicar 2011). McGrail (2011) found that GPs with 6-18 and specialists with 11-18 childhood years in a rural location were

statistically more likely to be working in a rural setting. Wolstencroft and Macvicar (2011) stated that a rural upbringing fuelled the practitioner's interest in rural practice and the existence of personal relationships and family ties were identified as 'powerful motivators for retention' (Keane et al, 2012, p3).

Attracting practitioners with a rural upbringing has the potential to be an effective way of improving the workforce turn over in rural settings, however it is unlikely that this strategy alone will be sufficient in addressing the recruitment and retention problems in rural practice. Alternative initiatives are needed to attract staff from non-rural backgrounds as well as entice back those who grew up in this setting. The literature in this section highlighted the key challenges facing practitioners working in the small community, but failed to capture the process of acculturation the 'outsider' may go through when they move to a new community, especially if it is situated in a different country.

Acculturation processes - the impact on recruitment and retention.

Acculturation; theoretical positions and the factors impacting on the process

According to Sam (2006), there is no definitive meaning or operational definition for the term acculturation despite its widespread use in the literature. He goes on to propose that acculturation is 'all the changes that arise following "contact" between individuals and groups from different cultural backgrounds' (p11). It is recognised that the changes occurring at a group level are associated with the socio-political infrastructure of the group whilst changes at an individual level are affective, behavioural and cognitive in nature (Sam 2006). In view that the proposed study will be focussing on the individual experiences of RNs and not groups of people migrating from another country, the theories considered here are related to the acculturation process of the individual.

Muecke et al, (2011) undertook a literature review around the concept of culture shock and cultural adaptation. Culture shock is the 'stress, anxiety or discomfort' (p2) an individual may feel when they are placed in an unfamiliar environment. Cultural adaptation occurs when this culture shock is well managed and the person experiences growth and development. Muecke et al, (2011) state that an individual

experiencing culture shock goes through a number of stages. This four stage model was first mooted by Oberg (1960 cited in Muecke et al, 2011) and has since been developed further to include the following phases: the honeymoon stage, when the new comer feels elated and fascinated by their new experiences; the rejection stage, marks the beginning of culture shock and disenchantment with the new situation; the beginning resolution stage, the newcomer begins to recover and cope with their new situation; and the effective functioning stage when the new comer has acculturated and becomes a functioning member of the community. Hofstede et al, (2010) state that the time taken to move through these phases is dependent on the length of time the newcomer is planning to stay; the shorter the period of time the quicker the individual will move through the different phases. The individuals included in the study will have been or plan to be in post for various time frames, some of these are imposed, others are through choice. Equally this theory could provide insight into the similarities and differences of the acculturation process as experienced by the study participants.

Ward et al, (2005) are critical of Oberg's model and other models which are based on a 'U-curve' hypothesis such as Lysgaard's (1955 cited in Ward et al, 2005). They go on to state that even though the evidence supporting these models is inconclusive and speculative one of the reasons why this apparently 'thin' theoretical perspective has maintained a strong position in the field is due to the lack of a convincing alternative framework. Ward et al, (2005) suggest that this is due to the inherent difficulties in conducting longitudinal studies with new comers, both in terms of their cooperation to participate in the research and the identification of appropriate time intervals for data collection. They posited that much of the research has been conducted within discipline specific paradigms which have not permitted a more integrated approach to the study of culture shock and the issues associated with cross-cultural contact in general. As a consequence Ward et al, (2005) offer a model of culture shock which is based on the themes arising from the existent literature of cultural contact and include the following categories: Stress and coping, cultural learning and social identity. These categories will be used to provide further insight into the acculturation process as experienced by the individual and the resultant outcome of that process.

The literature indicates that there are multiple factors impacting on the acculturation process. Hofstede et al, (2010) suggest that cultures can differ on a number of

dimensions and that the further apart the cultures are on these dimensions so the potential for conflict increases (Muecke et al, 2011). One particular dimension which receives much attention in the literature related to the acculturation of Asian health and social care professionals, is the individualism-collectivism continuum (Cheng and Liou 2011; Ea et al, 2008; Hayne et al, 2009; Yi and Jezewski 2000; Beechinor and Fitzpatrick 2007). A collectivist culture such as that found in Asian societies is concerned with the interests of the group over the interest of the individual whereas the opposite is true of individualist societies such as Great Britain and America. This can be problematic when the two cultural groups work together. For example Korean nurses who originate from a collectivist society view the individualistic behaviour of American nurses as 'self-centred' (Yi and Jezewski 2000). At the same time American nurses have been shown to impose their own individualistic values on Filipino nurses, by expecting the members of this cultural group to ask for help if they are unsure of what is expected of them (Hayne et al, 2009). Whilst this literature suggests that teams consisting of a cultural mix of collectivists and individualists could be ineffective and prone to conflict, Hofstede (2010) warns that the uni-dimensional individualism-collectivism continuum exists at society level only and cannot be transferred to the level of the individual. He suggests that both individualist and collectivist values can co-exist within an individual and should be treated as two-dimensional; people can score high on both, low on both, and anything in between regardless of ethnic background.

Another key factor impacting on the acculturation process is the personality and characteristics of the individual themselves. This includes their language proficiency and ability to communicate effectively within the new culture (Beechinor and Fitzpatrick 2007; Ea et al, 2008, Newton et al, 2012; Al-Omari and Pallikkathayil 2008). Previous experience in other cultures is also found to contribute to a positive outcome (Muecke et al, 2011). The ability of the individual to support good self-care and coping strategies so as to preserve emotional, physical and mental health appears to be a common theme (Hayne et al, 2009; Le and Kirkpatrick 2008; Newton et al, 2012; Sochan and Singh 2007; Beechinor and Fitzpatrick 2007). In addition knowledge about the new culture, adaptability of the individual, and their willingness to socialise (Al-Omari and Pallikkathayil 2008, Ea et al, 2010) is another key factor for successful adaptation. Finally the cultural habits, traditions, dress and outward appearance of the individual

may influence the acculturation process (Padilla and Perez 2003; Al-Omari and Pallikkathayil 2008) especially with respect to the way they are received by the hosting culture (Padilla and Perez 2003; Beaton and Walsh 2010).

Finally the acculturation process can be influenced by situational factors. These include job related issues such as the job itself and the degree it meets expectations (Sochan and Singh 2007), the availability of support for the new-comer (Beaton and Walsh 2010; Beechinor and Fitzpatrick 2008; Jian 2012), the degree to which their experience was recognized in the workplace (Sherman and Eggenberger 2008) and the processes the individual may have to go through in order to be licensed in the host country (Beaton and Walsh 2010; Sherman and Eggenberger 2008; Sochan and Singh 2007; Woodbridge and Bland 2010) . In addition the presence of colleagues from similar cultural backgrounds enables the newcomer to maintain their cultural roots as well as provide a means of peer support (Sidebotham and Ahern 2011; Alexis and Shillingford 2011; Beechinor and Fitzpatrick 2008; Hayne et al, 2009; Ea et al, 2010). Lastly the acculturation process is influenced by the way the host community interacts with the newcomer and the availability of appropriate support to orientate the individual to the resources, services and housing available in the vicinity (Hayne et al, 2009; Han and Humphreys 2005; Al-Omari and Pallikkathayil 2008; Sherman and Eggenberger 2008).

This section has demonstrated the complexity of the acculturation process and the factors impacting on it. Although the literature within this field is diverse in that it crosses a number of disciplines including sociology, anthropology and psychology, it is evident from the reviews presented here that the body of knowledge has some way to go to provide a more integrated picture. That said the literature does provide some valuable insight into the range of challenges facing health and social care professionals, when they make the decision to work and live on the Islands. The issues highlighted from the literature will provide some direction as to areas which will need to be explored when collecting the data during the course of the study.

Issues related to the recruitment of staff from overseas.

A report by the World Health Organisation (WHO, 2006) demonstrated that there was a 4.3 million shortfall in healthcare workers across the world. The critical shortages were seen in areas of the developing world, whilst European countries appeared to have little or no shortfall at all. A report by the European Observatory on Health Systems and Policies (EOHSP, 2006) provides further insight into the workforce patterns in the UK. They highlight the fact that international recruitment has played a role in promoting staffing growth in the UK and is considered to be an 'integral' part in sustaining staffing levels in the NHS. The literature indicates that this form of recruitment is employed by other developed countries such as America, Canada and Australia (Kingma 2007). It also highlights that, despite the apparent lack of shortfall of healthcare workers in Europe, there is still a degree of migration of workers from eastern to western European Countries which are typically the longer standing members of the European Union (Buchan 2008). As a consequence of the apparent global migration of healthcare workers there is a plethora of literature addressing the issues and challenges associated with this trend.

In view of the fact that the migration of the workforce seems to be a one way flow from economically challenged countries to those who enjoy greater affluence, has raised ethical questions around the recruitment practices of the developed countries (Ea et al, 2008; Priester and Reinardy 2003; Kingma 2007). The International Council of Nurses (ICN, 2005) recognised the need for policy makers to monitor the costs and benefits associated with the apparent brain-drain from source countries. In their conclusion they recognise that developed countries exhibit certain 'pull factors' such as 'better pay, professional development and improved career opportunities' (p28) which can entice immigrants. These forces are further boosted by the 'push factors' such as 'low pay, poor career prospects, unsafe environments and instability' (p28) which exist in the source countries. Whilst it is acknowledged that developing countries can benefit from the higher levels of income that the immigrant will receive and subsequently supplement their family's income 'back home' (Woodbridge and Bland, 2010), there is still concern that current arrangements are a win-lose situation with the source country being the loser (ICN, 2005).

In 2010, the WHO developed a Global Code of Practice which set out to discourage 'active recruitment' from countries which have a critical shortage of healthcare workers. The code does encourage member countries to resource their own workforce needs where possible. However Kingma (2007) warns that 'International mobility is a reality in a globalized world, one that will not be regulated out of existence' (p1294). Therefore 'Article 4 - responsibilities, rights and recruitment practices' of the WHO code (2010) should continue to play an important role in ensuring that healthcare workers recruited from overseas are treated fairly by the host country and are provided with appropriate induction programmes. Although much of the literature reviewed here predates the WHO code and may not reflect current practice, the fact that member countries are not mandated to comply with the code implies that these studies may still hold some relevance.

It is evident that from the push and pull factors identified above that migrants will have certain future expectations that they will want fulfilled when they take up post in the receiving country (Van Oudenhoven, 2006). These expectations may be further shaped by the knowledge and information the migrant has of the host country prior to moving (Al-Omari and Pallikkathayil, 2008). Al-Omari and Pallikkathayil, 2008) suggest that these future expectations and the knowledge and education the migrant has received about the host country are two of the eight antecedent conditions which need to happen before the individual can achieve psychological acculturation. Therefore it is unsurprising that immigrants who are not informed of what to expect when they take up residence in the host country find the process of moving to the new country a somewhat stressful experience (Alexis and Shillingford, 2011). This issue will be considered further in the next section which will explore the concept of acculturation further.

Retention of overseas staff, influencing whether they leave or stay

The recruitment of health and social care professionals is a costly and increasingly difficult process. The need to seek alternative pools of recruits has led to the employment of staff from overseas, who, as highlighted earlier, are 'pulled' by the prospect of better pay and standard of living from those countries who cannot offer the same incentives.

It is one thing attracting new recruits but retaining them as employees is another matter. One strategy employed in Canada was the use of incentives. These included paying for the airfare of the new employee, paying for the return flight on completion of their contract, offering subsidised accommodation, providing laundered uniforms and offering higher salaries (Beaton and Walsh, 2010). However Beaton and Walsh's (2010) study indicated that the reasons why nurses from overseas decided to stay in Canada was more to do with the following: An improved life-style; Marriage to a local person; The safety of the environment for bringing up children; Better and less stressful working conditions. This indicates that while monetary incentives have a place in the retention of staff, the reasons they cite for staying are more qualitative in nature.

Malinen and Johnston (2011) supported this notion in their study which found that a major attraction for recruiting nurses to New Zealand was the promise of a better lifestyle. Their small scale study indicated that new recruits did feel that their standard of living had improved and that their expectations were being met. The authors draw the conclusion that employers who met these expectations through flexible working practices would promote the retention of staff. These studies included small samples of staff who were migrating from UK, North America and Europe to countries with similar cultural backgrounds and therefore has transferability for those UK recruits coming to work in Guernsey.

Sochan and Singh (2007) describe a scenario of Asian nurses having their 'Canadian dream shattered' when faced with the credentialing process they had to go through in order to work as a licensed nurse. The disillusionment they felt resulted from the mismatch in their expectations and the reality of working in Canada. Although these studies are small, it could be concluded that the management of expectations is an important part in both smoothing the acculturation process and increasing the likelihood that the new recruit will remain in employment.

Another key area identified by Le and Kirkpatrick (2008) was the importance of social capital at 'family, community and institutional levels'. Social capital is generated through the development of social networks which provide a non-tangible social

resource for the individuals which constitute that network, and in some cases, those on the periphery as well (Putnam, 2001). This social resource provides a means of support, a sense of belonging, access to information and mutual aid. In addition Putnam (2001) argues that countries with high levels of social capital are correlated with lower rates of murder, better health outcomes and less economic inequality amongst its inhabitants. Whilst the focus here is on the social capital available to the newcomer, this theory indicates that existing community members are also set to gain from the efforts of promoting inclusivity through established and new social mechanisms.

The social capital associated with family connections can be maintained by allowing the new comer to bring their family with them so that existing relationships and responsibilities can continue (Le and Kirkpatrick, 2008; Han and Humphreys, 2005). In turn the local community needs to provide 'intercultural activities and resources' in the form of social networks to enable the individual and their family to develop friendships (Han and Humphreys, 2005; Al-Omari and Pallikkathayil, 2008). Finally, the institution should consider how they induct the new employee into the organisation and welcome them to the team (Alexis and Shillingford, 2011; Beaton and Walsh, 2010). Strategies such as the provision of mentorship, especially by peers from similar backgrounds (Hayne et al 2009; Sherman and Eggenberger, 2008) and on-going culturally sensitive developmental programmes (Newton et al, 2012; Sempowski, 2004) all contribute to the individual and their family 'feeling at home'; thereby increasing the likelihood that they will stay (Ea et al, 2008; Le and Kirkpatrick, 2008).

The studies cited in this section are predominantly qualitative, which gives good insight into the experiences of the study participants and the types of strategies which could be put in place to improve retention. It also provides candid accounts of where these strategies have not been in place and the new comer has been subjected to prejudice and discrimination both in the community and in the workplace (Alexis and Shillingford, 2011; Han and Humphreys, 2005; Newton et al, 2012; Sidebotham et al, 2010). They have felt a sense of loss and loneliness having moved away from their family network (Beechinor and Fitzpatrick, 2008) and have been disappointed when their prior expectations of their new life have not been met (Sochan and Singh, 2007). Although it is possible to draw some conclusions about the strategies that seem to work in the

retention of staff from overseas, there is a dearth of literature related to the effectiveness of these strategies in retaining staff. It is also interesting to note the similarities in the strategies employed to retain staff from overseas with those identified earlier in relation to staff retention in rural contexts. However, there has been a lack of evaluation of these strategies in the rural field.

This review of the literature has highlighted a number of key issues related to the challenges of working in a small island community and has such has raised many potential avenues for further enquiry. These include the following:

- 1) What are the key challenges that new recruits face when taking up post and practicing as a RN in Guernsey and Alderney?
- 2) How do these challenges change for RNs who have been in post for many years?
- 3) What problems and tensions do new recruits face during the early phases of the acculturation process?
- 4) How do longer serving RNs cope with the context of Island life?
- 5) Are there any specific incentives which can attract staff to the Islands and reduce the current turnover?

CHAPTER THREE

Research design

This chapter will provide a critical account of the study methodology and methods used to complete this research project. I have written this chapter in the first person to ensure that I capture the reflexive approach that was used to design and undertake the study. This reflexive approach was essential as the research design evolved and changed iteratively, requiring a deal of decision-making on my part as the lead researcher. In addition, because I led the research study, collected the data and immersed myself in the analytical processes it would be misleading to use the 'passive voice' of the third person, as this would imply that I had maintained an 'objective distance' (Silverman, 2000). In addition, an early paper by Webb (1992) perceives the use of the first person as being an essential feature of qualitative research reports as this is consistent with the epistemological and ontological position of this approach to inquiry.

I will firstly outline how I developed the aims and objectives of the research and the conceptual framework which I used to direct the study. This will lead on to a critical account of the philosophical foundation underpinning my research along with the methodological approach I chose to achieve my study aim and objectives. I will go on to detail the research context, highlighting areas of particular relevance to this research. This will form a prelude to a discussion of the ethical challenges which faced me in both recruiting participants and completing the study. The rationale underpinning the choice of sampling, data collection and data analysis methods will be explored and justified against the alternative methods considered when developing my research protocol. Finally I will highlight the lessons I have learnt and the actions I would take when completing future studies.

Aims, Objectives and Conceptual framework

Although the background to this study detailed in chapter one provides an overview of the issues which prompted this inquiry and the extensive review of the literature helped to shape the direction of the study, identifying an original researchable problem was a

challenge. Silverman (2001) warns that 'social problems' as identified by managers and practitioners may be defined to 'serve vested interests' and reflect existing viewpoints. For example, managers know there is a problem with recruiting and retaining staff on the islands and some speculation has taken place as to why this is the case. However despite measures being put in place to address some of these issues, the problem remains unresolved. I wondered whether this was due to the problem being framed and addressed in a reductionist way, rather than considering the issue from the perspective of the employee. Having conducted an extensive literature review which crossed a range of disciplines, it became apparent that the recruitment and retention of staff in small communities was a highly complex and context dependent issue.

In order to gain 'new perspectives' on the recruitment and retention problem I have taken Silverman's (2001) advice which is to allow 'theoretical imperatives' to 'drive the direction' of the study. This enabled me to do three things:

Firstly, the literature review highlighted that the challenges practitioners faced in small communities can have both a positive and a negative impact on recruitment and retention. It therefore seemed prudent to develop the research aim in such a way that the emphasis was more on the challenges as experienced by employees rather than framing recruitment and retention as the central issue. As a consequence of this line of thought the aim of my research was, 'to explore the professional and personal challenges facing generalist Registered Nurses (RNs) working and living in two small island communities'.

Secondly, once I had decided on a suitable research methodology (this will be discussed later), I was able to develop a number of objectives for my study. These were derived from the themes arising from the literature review and are listed below:

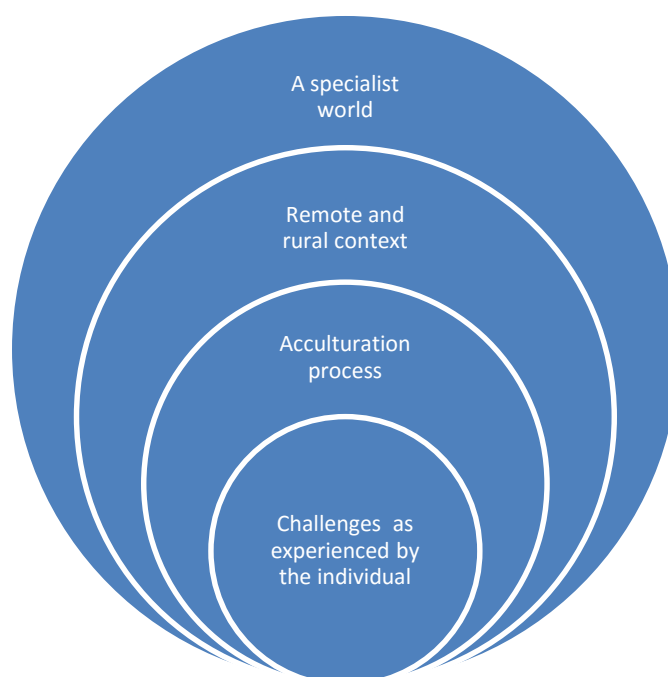
- 1) To analyse the stories of newly appointed generalist RNs to gain insights into their experiences of working and living within a small Island community during the first two years of appointment.
- 2) To analyse the stories of 'expert' generalist RNs who have been in working and living within a small island community for a minimum of five years.

3) To use the insights gained from this analysis to:

- a) Identify the challenges facing newly appointed RNs during the first two years of appointment.
- b) Establish the scope of the occupational role of the generalist 'expert' nurse employed in two small island communities and explicate the challenges they continue to face in their role.
- c) Identify strategies to prepare and support RNs to meet the challenges they may face when taking up post in a small island community.
- d) Contribute to the identification of the professional development needs and support required for generalist RNs to achieve 'expertise' in their professional roles within a small island community.
- e) Give 'voice' to the 'work' of the generalist RN employed in small island communities.

Thirdly, the literature review was very broad and disparate consisting of theories drawn from a range of health and social care disciplines as well as sociology and psychology. I decided that this theory would be more useful in supporting my research if it was pulled together into a unifying theoretical framework (see fig two). This would not only make it easier to 'work with' existing theory but it would also add a deal of originality to the way I have approached this study. I have placed the individual who is experiencing the challenges of working and living in a small community in the centre of the framework. The challenges as experienced by the individual are likely to be shaped by the acculturation process the individual will go through when they take up post on the islands. Therefore I have included theory related to acculturation in the first layer to provide some insight into how the individual both influences and responds to this process. The next layer relates to the challenges the individual faces by virtue of living and working in an island context. This can be better understood through the lens of the literature related to remote and rural practice. Finally the challenges are further influenced by the world view that has a tendency to lean towards specialist rather than generalist practice. The theory associated with the specialisation of professional work would fit here.

Fig two: Theoretical Framework



I intended to use this framework in a flexible and critical approach, I wanted it to provide some direction for my study but did not want it to be used in such a way that I found myself gathering and 'squeezing the data' so they fit. I hoped the framework would permit the emergence of serendipitous data and new insights, whilst producing a study which is theoretically sound.

Methodology

To meet the study aim and objectives an experience-centred narrative research methodology, as described by Squire (2008), was used to capture and analyse the 'stories' as told by the study participants. Narrative research, whilst open to a wide variety of interpretations within the literature (Overcash, 2003; Josephsson et al, 2006), has become a recognised approach to gathering data related to the experiences of employees working within healthcare and other organisational settings (Palmo 2010; Syrjala et al, 2009; Greenhalgh and Wengral 2008). There are also variations in the philosophical tenets underpinning narrative research (Heracleous and Barrett, 2001). I have decided to opt for a critical theory approach as it supports the notion of 'giving voice' to individuals who are marginalised by the prevailing 'big stories' or grand narratives that dominate society (Phoenix and Sparkes, 2009). The literature review indicates that there is a widely held perspective or grand narrative that

specialist healthcare delivered within large urban settings is the 'gold standard' (Rivett, 2016; Xakellis, 2005; Ayanian et al, 1994; Maclean et al, 2000). This in turn, has had a negative impact on the perceptions held about the healthcare provided within small communities and the attraction they hold for potential employees (Grobler et al, 2009). I believed that by allowing the participants in my study to 'give voice' to their experiences through the interpretation of their 'small stories' (Orbuch, 1997), they have been given an opportunity to be heard by policy-makers who are 'deafened' by the widely accepted 'big stories'.

One of the main criticisms of employing 'story-telling' as a research method, is that it is personal, biased and unscientific; stories may be fabricated or exaggerated and hold little value in terms of generalisability (Koch, 1998). It is also argued that this dominant grand narrative may influence the content of the 'small story' and the way it is interpreted (Blumenreich, 2004). However stories reflect reality as constructed by the story-teller (Aranda and Street, 2000) and are 'convincing' by their impact (Greenhalgh et al, 2005). The reflexive approach of critical hermeneutics provided me with an opportunity to search for meaning within the story and then critically evaluate this meaning in order to generate new understandings and perspectives (Moen, 2006; Palmo 2010; Squire 2008). I will expand on this further in the data analysis section.

Setting

The study took place within an organisation delivering health and social care on the islands of Alderney (Population 2000) and Guernsey (population 63,000). Although there is no agreed definition for what is a rural/small community/underserved context, for the purpose of this study the following was used as the operational definition:

'it reflects smaller populations, and distance and isolation from major centres with a corresponding lack of access to the full range of services and infrastructure' (Paliadelis et al, 2012, p2)

Whilst the Islands have strong links to the UK, they are independently governed, with each island having its own 'Government' to create legislation. As a consequence the legislation in the Islands differs to the UK. Some legislation created in Guernsey applies to Alderney, this includes law related to 'transferred' services such as health

and social services. The health and social services in Alderney are managed by the States of Guernsey, Health and Social Services Department (HSSD).

The health and social care system in the Islands differs from that offered in the UK. Primary care services are privately managed as businesses and incur an 'out of pocket' cost for people wishing to access them. Some of this cost is supplemented by the States of Guernsey Social Security Department through compulsory insurance contributions. Physiotherapy services requested through primary care, the use of the ambulance service, dental treatments and care in the accident and emergency department in Guernsey also incur a charge to the service user.

Alderney has a small 22 bedded community hospital, which provides continuing care for older people with physical and mental health problems. It also provides acute medical and surgical care, maternity services, community nursing services and urgent care. HSSD has a contract with the Island GPs to provide medical care for in-patients. 'Specialist' health and social care professionals from Guernsey provide out-patient care, either in Guernsey or by running clinics in Alderney. Alderney patients also have access to the HSSD services offered in Guernsey especially surgical and medical services, maternity care and critical care.

The HSSD services in Guernsey has a broad remit including community nursing services, secondary care, some continuing care of older people with physical and mental health problems, acute and enduring mental health services, learning and physical disabilities services, and social care for children and older people. These are provided with a budget of £104million and 2000 staff. In addition the secondary care services are provided by the Medical Specialist Group (MSG) which is a privately run business consisting of 39 consultants who provide surgical, anaesthetic, medical, and paediatric care. This care is delivered through a contract and is funded by SSD with the compulsory insurance contributions. The local general hospital has approximately 200 beds and includes, a critical care unit, neonatal intensive care unit, children's ward, a private ward, 2 medical and 2 surgical wards, 4 theatres, maternity unit, day patient unit, endoscopy suite, a comprehensive radiology service, 5 renal stations and an A&E department which is run by the GPs. There are no junior doctors and at night there is only one resident GP supported by an 'on-call' system. The mental health

services are provided by states employed consultants. There is one acute admission unit which provides care for people with acute mental health problems. In addition, some health and social services are provided by the UK, either by 'visiting' specialists or in some instances residents are sent to the UK for specialist treatment or care; this is state funded. Both islands are therefore reliant on the ability to travel between the islands and the UK in order to access services; especially Alderney residents.

All health and social care professionals working in Guernsey are required by law to be registered with the appropriate UK body which regulates their particular professional group (SoG, 1987). Any standards and codes of practice produced by these bodies will apply to the practice of these professional groups whilst they are working on the Islands.

Sampling method

Due to the nature of the methodology I have chosen for my research, there was no requirement for me to base the sample size on a power-calculation. However the sampling method needed to be 'theoretically grounded' and selected in accordance with the aim of the research (Silverman, 2000). The final number of participants was based on the pragmatic considerations of data collection and analysis which was likely to be time-consuming. Draper and Swift (2011) contend that a one hour semi-structured interview will generate about 30 pages of transcripts.

I originally planned to include a sample of 16 participants which consisted of:

a) A purposive sample of 8 RNs who meet the following criteria:

- *RN holding a generalist post; the post-holder may be registered as adult, mental health, children or learning disabilities*
- *RN has been in post for a maximum of 24 months*
- *RN has no previous experience of working or living in Guernsey or Alderney.*
- *Six RNs will be selected from Guernsey and 2 from Alderney*

These participants were the newly recruited RNs and had been selected to capture their initial experiences of working and living in either Guernsey or Alderney. It was anticipated that they would have been in post for a maximum of 24 months as this

is likely to be the period that had most impact in terms of the challenges the post-holder was faced with as they adjust to their new role.

b) A purposive sample of 8 RNs who meet the following criteria:

- *RN holding a generalist post; the post-holder may be registered on any part of the register.*
- *RN has been in post for a minimum of 5 years*
- *Six RNs will be selected from Guernsey and 2 from Alderney*

These participants were those who have developed expertise in their role. Benner (2001) suggests that on qualifying the RN makes a journey from being a novice at the first level to an expert at the fifth. In view that Benner expects the developing RN to reach level three within 3 years of taking up post it is proposed here that most RNs would require at least 5 years of experience to achieve level five.

Since I planned to use a software tool to assist with my data analysis I decided to extend my sample to include more participants. I requested a list of staff employed on a nursing grade who had been appointed within the last 2 years and another list of staff employed on a nursing grade who had been in post for a minimum of 5 years. These lists provided me with my sampling frame. In both cases I decided to obtain a purposeful sample which enabled maximum variation in terms of the fields of practice the participant worked in and their country of origin. I hoped this would both capture a set of diverse stories from across the organisation as well as identify any themes and patterns that have emerged despite the heterogeneous sample (Patton, 1990).

I selected 39 staff from the sampling frame of new recruits, ensuring that they were selected from a wide range of practice fields and from different countries of origin. I did the same thing for the 'expert' group and identified 29 possible participants. I then wrote to these potential recruits (68 in total) and provided a leaflet outlining the study and the commitments it would involve.

This method of recruitment was not very successful and so I decided to approach the potential participants in person. Although this method resulted in 20 newly appointed staff and 15 expert or 'long serving' members agreeing to take part, I was aware that

this approach could have been perceived as coercive. The fact that I asked the staff directly if they wanted to take part possibly made it more difficult for them to say no, for example 1 recruit said 'oh it is you, of course I will take part'. I was also aware that I had a good relationship with some of these staff members especially the people who have been working in the organisation for a long time. According to Pierce and Scherra (2004) and Bushy (2000) this is not an uncommon situation facing researchers conducting studies in small communities. However I was reassured by the fact that those people who were uncertain about taking part still felt able to refuse and the remainder appeared to have a genuine interest in the study and the possible outputs from it. All participants signed a consent form, this will be discussed further in the section addressing the ethical dimension of the study.

Data collection:

The study participants were asked to relate the story of their experiences of the key challenges they have faced as a generalist RN living and delivering care on the island. In keeping with a participatory approach, the participants were given a choice as to whether they wished to use visual, written or verbal media to convey their story.

- a) The visual data could be in the form of photos, pictures or collages (Baker and Wang, 2006), but should be meaningful in terms of their experiences.
- b) The written data could be in the form of a diary or a single written account, which reflected their experiences (Holloway and Freshwater, 2007).
- c) The verbal data could be in the form of an audio diary, or a single recording of their experiences (Monrouxe, 2009)
- d) The participant could use more than one medium if they wished such as a diary and pictures to enhance the richness of the data.

Providing a choice of media enabled the participant to select the one(s) that they felt most comfortable with when trying to express their stories (Woodhouse 2012). Oliffe et al, (2008) suggest that visual methods of gathering data provide an alternative mode of capturing experiences and cultural insights from the perspective of the participant, especially if the participant is given the opportunity to produce the data themselves. This has been facilitated by the development of digital technology to produce photographs and videos (Iedema et al, 2006). Since some of the participants do not

hold English as their first language they may have preferred to use an alternative medium to written communication to relay their story.

On completing their story the participants were requested to submit their account to me so that I could arrange a follow up interview in a location convenient to the participant. This semi-structured interview was to be used to clarify the story with the participant and establish their initial thoughts about the accounts they had written. The intention here was to develop a more complete account of their experiences as well as establish a rapport between the researcher and participant; an important requisite for this type of methodology (Aranda and Street, 2000). I developed an interview script based on the conceptual framework (Appendices 6 & 7). This script acted as a guide to explore the participants experiences of; acculturation, living and working in a small community and the impact of specialisation on their work as a generalist practitioner. This guide ensured that the same lines of questioning were used for all the participants, ensuring that there was consistency in the interviewing process (Patton, 1990). This semi-structured interview was recorded using an MP3 player to create a digital recording which was clearer and easier to store than a tape recorder (Fernandez and Griffiths, 2007). I transcribed these recordings using Express scribe® software. During the course of the study it became apparent that the participants were finding the compilation of a story before the interview too onerous and time consuming. I decided to give the participants the option of only being interviewed.

The duration of the interviews ranged from 30 minutes through to over 100 minutes; DiCicco-Bloom and Crabtree (2006) consider this to be a common length of time for this type of interview. I had been expecting the interviews to take at least an hour, but I realised that the fact that the participants had been briefed beforehand and some had already related their story in written or visual media, the amount of thinking time during the interview was going to be reduced. The interviews took place in either a private office or in an interview room, as requested by the participant. I hoped that this would ensure that they were comfortable with their surroundings, providing a suitable environment to hold an interview of this nature (Bold, 2012). I noticed that some participants were nervous initially and so made sure that non-emotive questions were asked first to allow them to relax and become more comfortable with the situation (Noonan, 2013).

Although I had an interview script, I tried to maintain a sense of informality by making the interaction more of a conversation than an interview (Patton 1990). I allowed the interviewee to respond freely even if they deviated away from the topics highlighted on my script. I was aware that I had good interviewing skills by virtue of my professional background in that I could use probing techniques to enable the participant to give a full response to my questions, and was able to summarise and paraphrase to check with the respondent that I had understood what they were saying (Noonan, 2013). I was also aware that when I came to listen to the recordings of my interviews that my questions were sometimes leading and that the intonation of my voice changed when the respondent said something I agreed with. Having said this, I did notice that in many cases when I asked a leading question, the respondent was not afraid to disagree with my line of thought. I was also surprised how open the respondents were about their experiences. The degree of candour with which they disclosed their thoughts and feelings went some way to reassure me that they were not tempering their responses to only those they thought I wanted to hear.

On reflection I think the flaws in my interview technique were very much overcome by the high level of rapport I had with the participants and the cathartic nature of the 'story telling' process which fosters safe disclosure (Jack, 2010; Fontana and Fray 2000). I realise now that I was 'naturally' using illustrative examples when posing questions, to demonstrate to the interviewee that it was acceptable for them to give negative responses which may reflect the short-comings of the organisation (Patton 1990). I was also trying to provide feedback to the interviewee to encourage them to continue with their story, a technique supported by Patton (1990). I did consider the idea of making notes of the non-verbal responses of the interviewees whilst interviewing them, as this would have contributed to the interpretation of the stories. However I thought that this might be too distracting and interfere with the natural flow of the interview. Also my 'field notes' and subsequent analysis of them could not be scrutinised in the same way as the data I obtained through other means (Silverman, 2000).

Although I didn't transcribe the interviews straight away, I did make notes on my developing ideas about the data and the patterns I saw emerging as I completed the

interviews. I shared some of these ideas with the participants when their Interview came to an end, to gauge their opinions and stimulate their own thoughts. I think there were some advantages in transcribing the interviews sometime after the event. Firstly I was able to listen to the interview with a fresh perspective, as if for the first time, this stimulated me to develop my initial analysis a little further. Secondly I felt I was able to tune into the different ways that laughter, pauses, humour, intonation, repetition and language were used in the story telling process. Listening to the recordings sometime after the event made me realise how these elements are also data because they shape the narratives and contribute to the way they are interpreted (Bold. 2012; Silverman. 2000). Thirdly I had selected a heterogenous sample to obtain a diverse set of narratives which I wanted to analyse as a whole, as well as look for themes. Data saturation was not my main goal in this instance so engaging in formal analytical processes at the data collection stage was not a priority.

I kept a reflective diary for the duration of the study, to record my thoughts and feelings as well as track my decision-making processes. I was aware that I had various roles within the organisation which may impact on my relationship with the participants. In some cases I had known the participants for nearly 20 years and therefore had developed an opinion on 'how they are ' as people which could influence the way I collected and analysed the data they provided (Carolan, 2003). Clancy (2013) states that to be truly reflexive, researchers 'need to stand back from their understandings and views of the world to see how and why interpretations have been made' (p15). Clarke (2009) believes that maintaining a diary can help to develop a reflexive approach to the research process and in so doing contribute to the auditability and trustworthiness of the research. I initially planned to structure my diary entries as suggested by Blaxter et al, (2001). However as Clarke (2009) states a diary is a personal document and will only be 'as good as the author wants it to be' (p72).

I decided to not confine my diary entries to any particular structure and allowed myself to write freely and honestly about my thoughts and feelings. I found this process particularly cathartic especially when I came to listen to the recordings of the interviews during the transcribing process; I was totally unprepared for the emotions that I experienced. Pellatt (2003) states that feelings and emotions can arise as a result of the researcher coming from an 'assumed position of knowing' which enables them to

empathise with the participants. I came back to live and work on the island in 1989, therefore I was only too familiar with some of the challenges and frustrations voiced by the participants. Expressing these emotions in my diary helped me to identify my own position in the research process and how this may affect the interpretation of the data (Pellatt, 2003).

Finally I was mindful that I would need to pull on additional material to help make sense of the contextual background which was insitu during the time that the data collection was taking place. Squire (2008) suggests that this additional material can take the form of different types of media, including oral, written and visual texts. I decided to select these once I had finished transcribing the interviews. The initial crude analysis of the data that I was making as I listened to the interviews during the transcribing process guided me as to the types of contextual information I needed to help me analyse the data.

Data Analysis

I had difficulty in deciding on a suitable method to analyse the data. I think this was due to a number of reasons: Firstly, as Squire et al, states (2008) there is no one recognised way of analysing narratives, so a prescribed process was not available; secondly I knew that I would have a range of data to analyse in both written and visual media and that these may need to be handled differently; thirdly I was aware that I had lived and worked within one of the island contexts for over 20 years and was likely to have a subjective influence over the way the data were analysed; fourthly I wanted to analyse the stories as entities in themselves as well as identify themes arising from them as a data set; finally, whilst I wanted the study to be supported by a theoretical framework, I was mindful that I wished to challenge existing ways of viewing and interpreting the narratives to gain new understandings about the participants' experiences.

In addition, narrative research is considered to be temporal and context dependent. However it can be argued that there is a continuum as to how far the context is involved in the 'meaning-making' process when interpreting the data (Silverman, 2001; Sandelowski 1999). Hansen (2006) suggests that this continuum can range from just

the narrative being analysed through to an ethno-narrative approach where the context and narrative are in an 'endosymbiotic relationship'. I wanted this study to adopt a position between these two extremes where the narrative is still the main focus of data analysis but the context is recognised as situating or framing the production of the narrative. This approach would enable the context, to be 'called on' to help interpret the narrative and to highlight how the local, national and international contexts shape and contribute to the interpretations of the narratives situated within them (Hansen 2006). It was important to consider these three perspectives, as the participants were living and working within the local context, they originated from countries across the globe and despite the Islands being independently governed, national and global policies still have impact on the personal and professional lives of the communities living on the two Islands.

On considering the literature it was apparent that hermeneutic analysis was a possible approach that I could use to analyse the written data. Hermeneutics is a term which refers to a 'family of interpretative approaches' which have evolved since their inception in the 17th century (Patterson and Williams, 2002). Although it is a recognised method used primarily for the interpretation of texts it has also been used to analyse works of art as well as data derived from interviews and observations (Patton, 2002). There are a number of philosophical positions associated with hermeneutics, depending on whether the researcher's preconceptions are 'bracketed out' in an attempt to achieve an objective interpretation of the data or whether the researcher uses their preconceptions to help construct meaning from the data.

Heidegger shunned the objective stance towards hermeneutics by recognising that the participant makes sense of the data through the lens of their prior understandings (Dowling 2004). He went on to develop the hermeneutic circle which suggests that the researcher interprets parts of the data by relating it to the whole data set and the context in which it was generated and in turn makes sense of the whole by considering how it relates to the parts (Patton 2002). I thought this would fit well with the aim and objectives of my research as I wanted to analyse the narratives as separate entities to gain a sense of the form and structure of the narratives whilst identifying the themes within them. I also wanted to compare the stories and the themes within and between

different groups of participants, and then use this analysis of the groups to interpret the data set as a whole entity.

On further exploration of the differing schools of thought, Gadamer (1989 cited in Dowling, 2004), raised the issue that the preconceived ideas of researchers may be prejudiced which, in turn, will obstruct rather than facilitate their ability to interpret or understand the data. He suggests that researchers 'must not attach blindly' to their own 'fore-meanings' and be open to alternative ways of interpretation (Dowling 2004). Although these ideas are associated with critical hermeneutics it is the work of Habermas (1990) which truly embraces the critical paradigm's epistemological view that knowledge is dynamic but 'entrenched in a socio-political context' (cited in Dowling 2004, p36). According to Geanellos (2000), Habermas is not only concerned about recognising the entrenching power of prejudice in the hermeneutic process but believed that the researcher should be critically reflecting on how these presuppositions and 'unquestioned traditions' came to be part of their understanding (1990 cited in Dowling 2004). In view that I am very 'close' to the research context and have a relationship with many of the participants, it is imperative that I challenge my presuppositions, prejudices and knowledge of the local traditions which would obstruct my ability to understand the data. However it is the work of Paul Ricoeur, which I have chosen as a basis for the data analysis. He builds on the work of both Gadamer and Habermas in an attempt to capitalise on the strengths of the two theoretical positions (Geanellos 2000).

Although Ricoeur doesn't claim to 'take sides', his work, 'Theory of Interpretation' is considered to 'sit' within the critical paradigm, which reflects my personal epistemological position which is to generate knowledge to affect social and political change. The challenges of living and working in the islands has not been explored systematically, although some conclusions have been drawn through the informal interviews which are conducted with staff leaving the islands. This has led to the development of presuppositions that have been used as a basis for addressing the recruitment and retention problem. In view that the problem still exists indicates that these presuppositions need to be challenged; using Ricoeur's work as a basis for the data analysis would go some way in enabling me to do this.

The analytical process

The diagram below (Fig three) depicts the process I took to analyse the data. The data set included 35 transcripts, 14 written stories, 1 video and 3 sets of photographs. The data were inputted into NVivo version 10. I used this tool to facilitate the analysis of the data for a number of reasons. Firstly it enabled me to handle the data more efficiently, allowing me to increase the number and variation of participants in my research study (Alcock and Iphofen, 2007). Secondly, Ricouer's concept of distanciation requires the data set to be freed from the context in which it is written, the act of inputting the data into the software, helped me to view the data as text and visual material requiring analysis. Thirdly NVIVO enables the analysis of visual, audio and written media (Bergin 2011); I had all three types to manage. Finally I had inputted the literature related to my conceptual framework into NVIVO, therefore it made sense to use this programme to help make the links between the framework and the interpretation of the data (Bergin 2011).

I used a coding system to analyse the textual data, noting the use of language, pauses, laughter as well as the content itself. These codes were amalgamated into categories which in turn were formulated into themes. Visual data were analysed and linked to the emerging categories and themes. This process was used to analyse each narrative as a separate entity, and the themes were explored in relation to the story as a whole. I interpreted the themes using the conceptual framework as well as contextual knowledge to deepen my understanding of what the narratives 'were saying' about the challenges experienced by the participants. I used Mezirow et al's (2000) transformational theory as a basis for the critical reflective approach I adopted during the course of the analysis. This helped me reflect on my assumptions and critically apply the conceptual framework and contextual knowledge to the developing interpretation of the narratives. I then selected 16 stories to analyse more closely; 8 were new recruits and 8 were from the expert group. These stories were chosen to reflect the diversity of backgrounds and experiences of the sample as a whole. I took the analyses of the individual narratives and then using a 'layered case study approach' as a structure (Patton, 2002), to compare the stories and themes within and between the subgroups and groups included in the study (fig. four). I finally amalgamated the findings from both groups (the new recruits and the experts) to

identify the common ground which exists in terms of the form and structure of the stories as a whole entity and the themes that have arisen when the parts of the narratives were analysed.

The decision as to how I would seek verification of the data to assure the rigour of the analytical process was a challenge. I was aware that I had a huge volume of data which took many months to analyse. I could have asked my practice supervisor to independently analyse the data as suggested by some qualitative researchers (Bowling, 2009). However this would not only have been time-consuming for her, but as Burnard et al, (2008) state it is likely that her interpretation of the data would deviate from my own, raising the question as to which interpretation is closer to the 'truth'. Instead of requesting independent analysis from my practice supervisor, I discussed the analytical processes with her and my emergent themes and ideas. She also read my written work as it was produced and together with Dr Alan Buckingham, provided supervisory guidance during phase 3.

I also considered the timing of completing a 'member-check' with the participants. There is some debate as to when and how this should occur (Gready 2008). Burnard et al, (2008) are sceptical about the value of this process, especially if not completed soon after the data is collected as respondents will have potentially changed the perceptions they held when the data was gathered. I made the decision to permit the respondents sight of the results section of the research prior to completing the thesis. This was more to check the protection of their anonymity in my 'write up' rather than their thoughts on the analysis. Those who chose to give feedback were satisfied with the way the findings were presented.

Fig three: Ricoeur's theory of interpretation

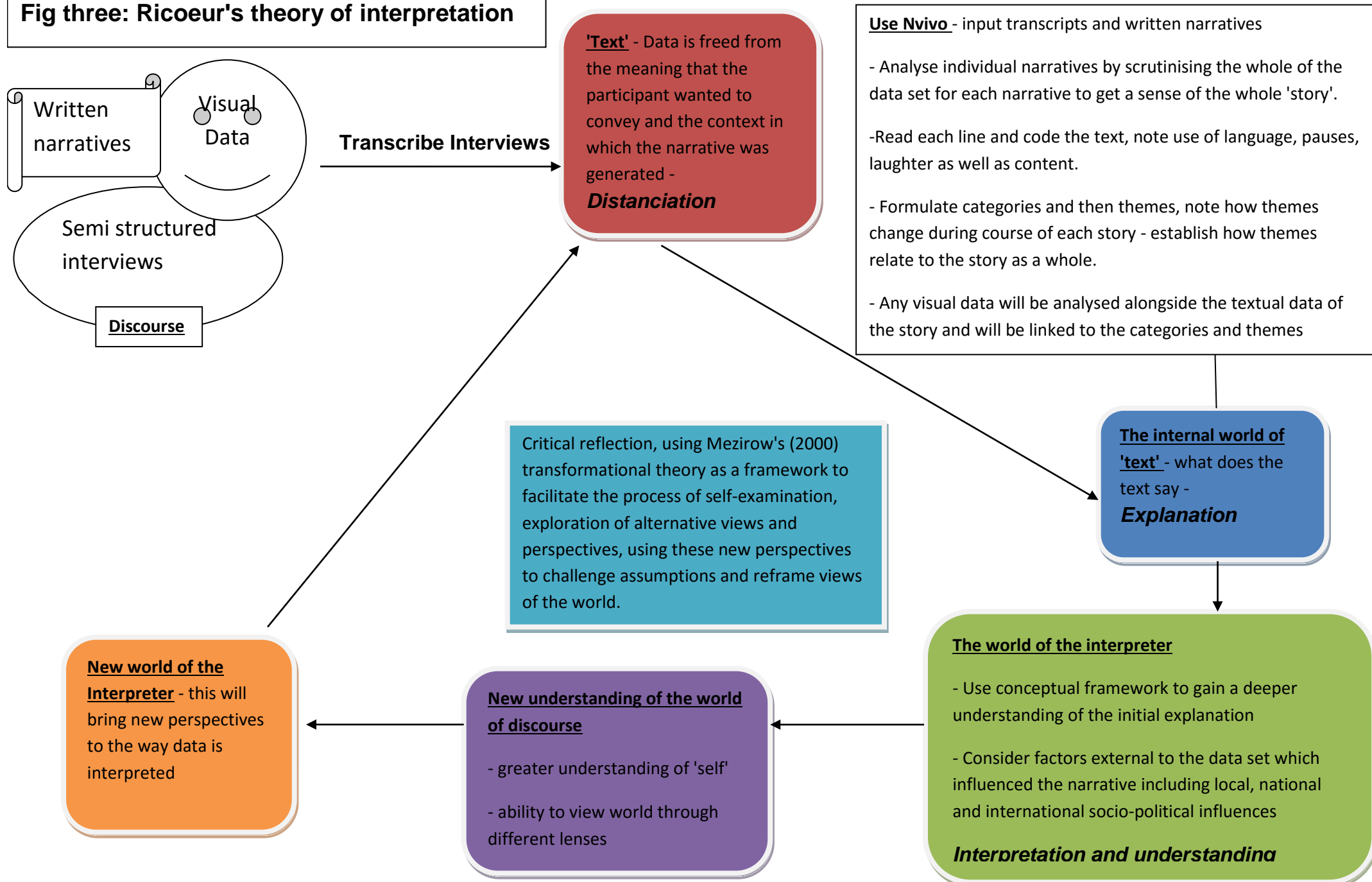
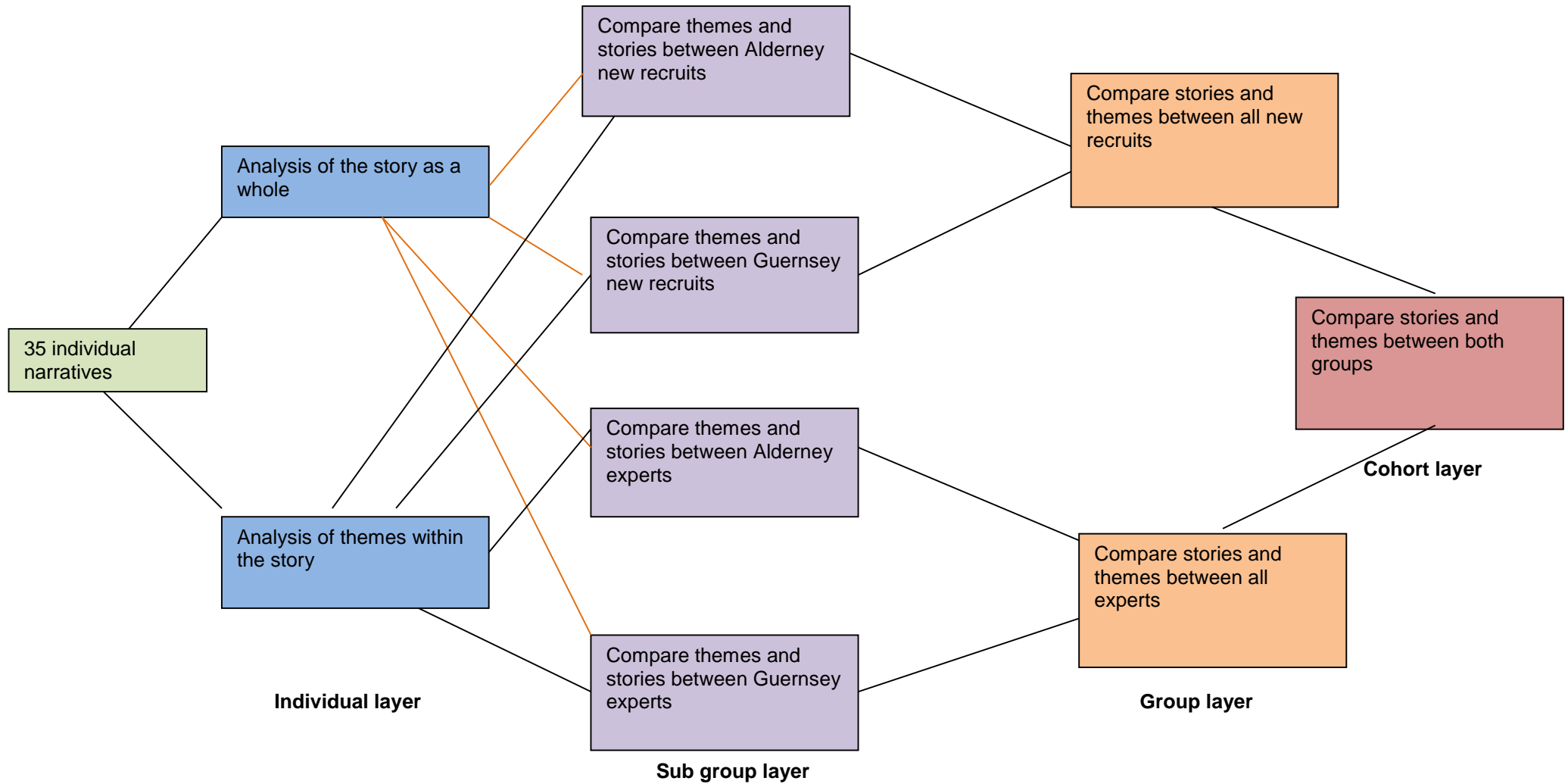


Fig. four: Layers of Analysis



Ethical implications

Ethical approval was obtained from the University of Bath and the local research ethics committee. The main areas of ethical concern were:

a) Benefits and risks

The benefits of the proposed study were identified in the background information discussed previously. In terms of benefit to the participant, the fact that the individual was given the opportunity to 'tell their story', provided them with a platform to recount their experiences as they perceived them (Overcash, 2003). However there were some inherent risks with this relationship;

- The participant may have perceived our relationship as being 'therapeutic' and revealed elements of their story they would have otherwise felt unwilling to share (Warne and McAndrew, 2010). This risk was managed through 'member checking' of the results section to ensure that the participants were satisfied with how their 'voices' were portrayed (Gready, 2008).
- There was the potential that the participants could become distressed during the data collection and analysis process, especially for those who had negative experiences (De Haene et al, 2010). I made it clear to the participant that they were free to withdraw from the study at any time and were given the opportunity to debrief after their interview. I had resources available from the Human Resources and Occupational Health Departments to support participants who may have required expert help.

b) Obtaining consent

The letter inviting individuals to take part in the study was accompanied by an information leaflet (Appendices one, two and three). The prospective participants were asked to meet individually with me to discuss the purpose of the study, the part they would play in the study and the time commitment involved. They were informed that they could withdraw from the study at any time without any repercussions. In addition the management of the data they provided would be in strict accordance to the Data protection (Bailiwick of Guernsey) Law, (SoG, 2001). I was required to store any data provided by the participant under password protection for computerised data or within

a locked facility for 'hard copies'. The individual participant was also made aware of what the data would be used for (Christians, 2000). The individual was also informed about the risks associated with the research, as detailed above, and the proposed solutions to manage those risks. Participants agreeing to take part in the study signed a consent form and received a follow up letter (appendix four and five).

c) Maintaining confidentiality and protecting anonymity.

Information provided by the participant during the research process remained confidential between the participant and myself. However if the participant had revealed anything that may have been detrimental to the safety of staff or service users, further action may have needed to be taken. I was guided by my own professional code (NMC 2015a) in terms of how these situations were to be managed. Protecting the anonymity of the participants was likely to be the biggest challenge and the area of greatest ethical concern. Alderney in particular has a very small close-knit community with less than 30 RNs employed by the Health Service. The nature of narrative research compounds this problem in that it is contextual and holistic (Holloway and Freshwater, 2007). However it is argued that this risk should not override the potential benefits of providing a 'voice' to the minority. This issue was managed by ensuring that obtaining informed consent was an on-going process between myself and the participant (De Haene et al, 2010; Holloway and Freshwater, 2007). I plan to submit the findings of my research for publication in a peer reviewed journal and present my findings locally and nationally. The participants will be kept informed of and, where possible, involved in these processes if they wish.

This chapter provided an overview of the methodology used to conduct my research. The process was an iterative one, resulting in a deviation from my initial plans as the study unfolded. The key point of learning in terms of the research process is the under estimation of the time it can take to complete and write up a study. Despite the steep learning curve the data gathered is both rich and plentiful and will be a useful form of evidence for the recruitment and retention strategy currently being developed. The next chapter will provide the results of the research study.

CHAPTER FOUR

Results

The following chapter will present the results of the research study and has been set out into four different sections. The first section will provide an overview of the participants included in the study. The second section will include additional details around the context within which the research took place. The third section will examine the final themes identified from the data analysis and consider the way in which the themes compare within the participant groups as well as between each of the groups and subgroups. Finally the interpretations of 16 of the 'stories' will be presented and also compared using a 'layered case study approach' as detailed in the methodology.

The participants

The participants were selected through a process of purposive sampling with the intention of obtaining a maximum variation in terms of their place of work within the organisation and their country of origin. Although this method of sampling does not secure a representative sample for generalisability, it does go some way to ensure that the participants included in the study reflect the diverse nature of the workforce in terms of their ethnicity and professional background; thereby increasing the transferability of the findings.

A total of 35 participants took part in the study, 15 were individuals who had been in post for over 5 years and 20 had been in post for less than 2 years (see table three); the former will be known as the long serving staff and the latter will be identified as the new recruits. Five of the participants were from Alderney, 2 were long-serving and 3 were new recruits. The participants were drawn from different fields of practice across the organisation including acute hospital services, community, mental health, learning disabilities, paediatrics and older people services. The 5 participants in Alderney were employed to work in the Island hospital and in the community setting. There were 14 female and 1 male participant in the long-serving group and 10 female and 10 male new recruits. Thirteen of the new recruits were under the age of 40 and 4 of the long-serving participants were in this age group.

Table three

Participants	Length of service when interviewed (in years)							
	< 1	1 < 1.5	1.5 < 2	5 < 10	10 < 15	15 < 20	25 < 30	30 < 35
New recruits	10	9	1					
Long- serving				1	6	3	4	1

In terms of their country of origin, the majority of participants were from the UK, representing all four countries. The remainder originated from The Philippines, Portugal, Finland, Southern Ireland, Africa and Australia. Thirty four of the participants held a RN Qualification, 1 held a dual qualification of RN and Midwife and 1 was a registered Operation Department Practitioner (ODP). Although the ODP was included erroneously in the sample group, a decision was made to include their narrative in the data set because the role of the ODP is very much aligned to that of the RN working in that setting. The participants held a number of different roles within the organisation, some were very junior staff nurses, whilst others held more senior management positions or more autonomous roles. All but the ODP were working as generalist RNs within their respective fields of practice. This section has provided an overview of the participants included in the study, it has been written in very general terms to protect the identity of the people involved.

The research context

The previous chapters have included a description of the study context in terms of the environment, the health and social care system and the recruitment and retention issues which gave rise to the need to conduct this study. This section will focus more on the significant events which were taking place whilst the research was being undertaken.

A strategy document was launched in 2011 known as the 2020 vision (HSSD, 2011). This vision for health and social care is that, by 2020 the foundations will be in place to enable all islanders to live healthy, independent lives. The key focus of this strategic document is to transform health and social services in order to promote the health and well-being of the community, to improve health outcomes for all and to protect people through high quality and well-regulated services. This work was to involve a review of health and social services in terms of the way it was configured and subsequently

delivered with the intention of driving out inefficiencies, deficiencies and inconsistencies. In addition to this significant piece of work, The Financial Transformation Programme was introduced in 2009 (SoG, 2016). The aim of this States of Guernsey wide initiative was to help 'close the deficit position by improving efficiency with the states of Guernsey'. The deficit position refers to the financial deficit which exists between annual revenue and the cost of providing public services; this shortfall equates to £31m. The FTP aims to meet this shortfall by setting a target for each Government Department to make efficiency savings each financial year. The target set in 2014 for HSSD was £4.7m.

Despite these targets, HSSD has not only failed to achieve its FTP target, it has also overspent the allocated budget. In December 2012, the over spend of £2.5m resulted in the resignation of the political board who were appointed in 2011 following the local elections. One of the surgical wards was closed for a year to address the over spend, resulting in the redeployment of staff, cancellation of operations and increase in waiting times. During 2013, the Chief Officer (CO) resigned and was replaced by an interim CO.

In addition to these changes, the states of Guernsey had commissioned a new States wide Information Management system to manage HR and Financial processes. Along with this new system and in line with the goals of the FTP, the HR and financial teams across the States of Guernsey were reviewed in order to centralise core functions with the intention of making efficiency savings. From January 2013 the new system, known commonly as SAP, became live across the States of Guernsey. At this time front line service staff were also being introduced to a number of computerised systems associated with patient records and provision of services.

The pressure to make financial savings continued into 2014, however the focus was switched to the HSSD midwifery services following an extraordinary review by the NMC (2014). This resulted in an 88 point action plan to address the identified shortfall in the service provision and the resignation of the Political board in the autumn. The repercussions of the midwifery review were widespread, including the suspension of all pre-registration nursing student placements. A new CO joined HSSD at this time,

who appointed a number of people from the UK to take up interim posts to support the changes needed to improve the governance infrastructure of the organisation.

The first half of 2015 has seen the students make a phased return to their programme as their placements are deemed fit to support them. The pace of change has been extraordinary during 2015, further hastened by the prospect of political elections taking place in 2016 and the disbanding of the current HSSD political Board In April the same year.

The narratives were obtained during 2012 and 2013. The analysis took place during 2013 and 2014, with the final interpretation taking place in 2015. As a consequence some of the narratives identify with the events which took place during 2012 and 2013. The more recent events however, provided further insight into the analysis and interpretation of the data derived from the narratives.

The final themes

Table four provides a synopsis of how the coding of the narratives were firstly amalgamated into categories. These were then translated into final themes which reflected the range of codes they represented. The themes were then grouped into 7 theme groups which in turn were linked to 5 different contexts: Individual context, characteristics and background; organisational context; island context; national context and global context. The conceptual framework identified in the methodology chapter was then aligned to these contexts and used to provide further interpretation of the results through a theoretical lens which is detailed in the next chapter.

Sixteen final themes were identified as a result of analysing the 35 narratives. The new recruits' narratives were coded first followed by the long serving participant narratives. Whilst there appeared to be little difference in the codes identified for each group of participants, resulting in the same themes emerging, the interpretation of each theme both within and between the groups does demonstrate some variation in the experiences of the participants. In addition, the codes and themes identified were very much interrelated with each other, resulting in a complex web of connections (appendix eight) demonstrating that the challenges of working and living in a small

community cannot be reduced to a series of isolated themes. With this in mind the final themes will be considered in turn, however evident connections between the themes will also be identified.

Table four: Developing the themes from codes

Codes	Categories	Final themes	Theme groups	Context	Conceptual framework
Communication	Communicating	Communicating effectively - linguistics and process	Modifiable characteristics	Individual context, characteristics and background	Acculturation process
Isolation, homesick, investing, making sacrifices, lack of anonymity, honeymoon period, discrimination	Acculturisation	Acculturation - a journey without end			
Making friends, hobbies, personality, honeymoon period	Coping strategies	Coping with Island life			
Love Guernsey, needs or partner and family, work life balance, values	Expectations	Great expectations and the match with reality			
Previous home, previous place of work, place of origin, place of training, year qualified, post-qualifying qualifications, history	Past experience	Experiences before island life	Non-modifiable characteristics		
Reason for move	Reason for move	Island life - the attraction			
Policies and guidelines	Policies and guidelines	Policies, guidelines, standards and protocol	Infrastructure	Organisational context	Remote and rural context
Gaps in the service, meeting client needs, resource issues, different healthcare system	Health and social care system	Health and social care systems - differences and similarities			
MDT issues positive and negative, agency staff	The MDT	Multi-disciplinary team - challenges and achievements	Team working		
Supervision, induction, support	Support	Sources of support			
accommodation, housing licence, politics, cost	Island Infrastructure	Island infrastructure - politics, legislation and economy	Policy and Legislation	Island context	
Relaxed environment, difficulty finding way around, doing a winter, orientation, slower pace, work and living boundaries, attitude of community	Island life	The island life experience - in the eye of the beholder			
Jack of all trades, skills and job profile, comparing roles, holistic care, training	Scope of practice	Managing the scope of practice	Professional and regulatory requirements	National context	A specialist world
Confidentiality, expert practice, accountability, autonomy	Professional accountability	Professional accountability -the specific challenges			
Staff turnover, incentives to stay, career opportunities	Recruitment and retention	Recruitment and retention - issues and solutions	Global Policy and trends t	Global context	
Specialist versus generalist	Specialisation	Specialist versus generalist - impact on care provision			

Global policy and trends

Recruitment and retention: issues and solutions

The issue of recruiting and retaining staff was the key driver for completing this study. It was therefore unsurprising that both the new recruits and the longer serving participants recognised that this was an issue for the two Islands. The factors which provided an incentive for the recruitment and retention of staff were identified by both groups. They were also able to offer some insight into the disincentives for staying in post for a prolonged period of time. However it is not possible to differentiate those factors which have a positive influence on recruitment and retention and those that do not as many of the factors appear to provide both an incentive to stay as well as a disincentive. This is exemplified by the following comment made about the financial bonuses and rent allowances offered to staff:

you get ...people [to] come, you set up a bonus scheme so they get bonuses after one and two years they get housing money help for two years so then it is all ensuring that people stay for 2 years and then people go ..

This new recruit indicated that the bonus scheme was an incentive to keep people on the Islands for two years but no longer. This was also recognised by one of the longer serving participants who felt the money used to pay the bonuses and subsidise rent could be used in a different way to provide a more sustainable workforce. However one long-serving staff member identified that despite staff turnover, the opportunity for staff to progress to senior grades is hampered by the lack of turnover at a more senior level. This could result in staff moving to acquire a promotion.

The paradox which exists between the factors impacting on recruitment and retention will have contributed to the inability to find definitive solutions to this long standing problem. These factors will be analysed in more detail in the themes identified below.

The resultant high staff turnover and vacancy rate in some areas has had impact on the provision of services. One new recruit highlighted how this created lack of continuity in care for people accessing mental health services. Another longer serving participant from Alderney provided some insight into their experiences of a high staff turnover:

Its constantly having to get someone up to .. standard again ... you might get someone come and take a job that has been working in a nursing home or has been working on a surgical ward but have never done A&E or elderly care with dementia patients or mental health

It is evident from this that new recruits require support to develop the skills needed to fulfil their role; this is particularly true for the people working in Alderney where they are expected to provide a very wide spectrum of care.

Specialist versus generalist – impact on care provision

The longer-serving participants were able to describe how the Island services had developed over the years. Whilst the trend has seen an increase in the number of specialist services available on the Islands, the challenge in providing such a wide scope of service within the limitations of the resources available was highlighted as an issue. One longer serving participant stated:

in the UK there is more space as in ground floor space so they tend to have more specialised units so you would have a younger disabled unit you would have younger disability unit you would have an older one whereas here we just don't have the space on the island to do that nor the competence to staff it nor the people you would need to put in it

This is further compounded by the expectations of the community that specialist services would be accessible on island to meet their individual needs. One of the longer serving participants stated that they have about 5 or 6 'contentious issues a year' involving parents who are demanding 'a gold plated service' recommended by a private therapist rather than accepting a more realistic package based on actual need. Moreover the development of national standards has provided additional pressure for services to mirror those available in the UK without the available resources. One of the longer serving participants reflected this perspective in the following statement:

I do have an issue when you have things that come out which stipulate one you should have a stroke unit you know in a small island we can't do that and the most recent one is stating that heart failure patients should be on a cardiac ward

As mentioned in the previous theme, new recruits usually present with a skills deficit on taking up post in the Islands; this is particularly true for those employed in Alderney. Conversely some new recruits have specialist skills that they are unable to use and consequently lose during their time in post. One of the new recruits recognised that this was a possibility, however they felt that the skills they were gaining made up for the skills they were losing.

Despite the move towards more specialist services nationally, the participants were able to identify the benefits of the more generalist provision available on the Islands. The range of learning opportunities in generalist settings was identified as a real positive and reflected the NMC standards of proficiency for RNs. One of the longer serving participants felt that the 'mix' of patients in the clinical areas reflected the diversity of the community and gave staff a 'better view of life'. This participant recognised that patients present with a number of care needs and not just one. A generalist experience provided 'staff with a wider scope to develop their skills and knowledge' and in so doing better prepared them for the complex care needs patients are now presenting with. Some of these issues will be considered further in the themes to follow.

Professional and regulatory requirements

Managing the scope of practice

In the main the participants supported the notion that the scope of practice of RNs working in the Islands was necessarily wide due to the economies of scale, the health and social care systems in place and the expectations of the community accessing the service. Whilst the wide scope of practice was related in the main to the clinical tasks and skills associated with their role, some of the participants were expected to take on a more managerial function than they had been exposed to in previous roles. Others were surprised that they had to undertake non-nursing functions especially 'out of hours'.

One of the new recruits felt that their role in Guernsey was very similar to the role they held in the UK, however they felt that there was less support from the specialist nurses as they were fewer in number:

suppose it makes us a bit more isolated because we have to use our expertise when I think of a community nurse I think we are a jack of all trades ...because we do all these different skills in these different areas but we are not experts in any of them, obviously wound management is quite a large proportion of our case load

Another new recruit from a mental health background felt that their current role did not differ too much from previous posts they have held, but they did point out that the facility they worked in was the only one of its kind in Guernsey. As a consequence clients presenting with a range of mental health disorders were all placed in the one unit resulting in a very varied client group. The participant pointed out that whilst it was possible to develop skills to meet the range of needs, problems occurred when the situation becomes 'critical' as the training is not enough to provide the required care. Registered nurses working in the paediatric ward were also faced with a wide range of clients aged between 0-18. A new recruit working in that area felt that they needed to be 'prepared for anything'. This included being able to transfer children off island to specialist facilities in the UK:

the kind of skills you need here are a lot different and you just want to be prepared I guess

This participant was keen to undertake any training available to ensure they were prepared and 'feel more secure'. They also pointed out that the slower pace enabled them to focus on the emotional care of the patients and their families something which was more difficult to achieve in the UK. In addition they felt that the lack of junior doctors required the nursing staff 'to be empowered to pick things up early' and communicate their concerns directly to the consultant. A second new recruit from the same area stated:

well it is a much smaller ward erm and it's a bit quieter so from a patient care perspective you get a lot more time with the patients which I enjoy and then because [the ward] has a neonatal unit and is a children's ward, that's different so I get a bit more experience than I would do if I was just working in a normal children's ward in the UK.

New recruits working in more general areas also commented on the range of patient problems cared for in a single environment:

you don't have your specialities like you go to the diabetic ward you go on to the vascular ward

everything is together so in my ward ... you could have someone with orthopaedic problems, gynae problems upper GI, colorectal, about everything and that is what I struggled with...

This participant and other new recruits saw this as a positive thing in that they could develop a greater breadth of skills. In fact some recruits were actively seeking new learning opportunities by undertaking bank shifts in different areas. However one new recruit pointed out:

if that learning is not properly supervised then it becomes a bit maverick erm and also what I personally believe is that any organisation will suffer if roles are not clearly defined

Whilst there was a perspective that the scope of practice was very wide, there were some new recruits who felt that they were losing some of their specialist skills due to the lack of opportunity to use them. This included management and leadership skills as well as some of their clinical ones. One of the new recruits was particularly vociferous in stating that the organisation was not capitalising on their specialist skills and expertise:

I feel slightly aggrieved that they are not thinking 'oh A's in post he has a qualification here we can really take advantage of we need to really sit him down and plan something around what he can do for us as well as what we can do for him' and that for me feels desperately lacking

Participants appear to develop a wide range of skills in Guernsey, however there is a danger that individuals can lose skills due to the lack of opportunity to use them. There is evidence to suggest that some people may have skills which could be used elsewhere in the organisation but they are limited by being bound to their role. In addition there is some question around the methods used to ensure that RNs learn the skills for their role in a systematic way. Although this issue was raised by one participant this perspective is worth exploring to ensure that the development of competence is a robust process.

The Alderney new recruits' scope of practice was very broad, the participants explained how they were expected to work with a range of client groups. This included people with mental health problems, those convalescing from surgery, people with medical problems as well as an emergency situations including trauma:

... this hospital is comprehensive structured where as a nurse you start from outpatients, A&E, you do medical in patients and the speciality being elderly care...

Another participant had been asked to work in the community as well as the hospital setting. They did not have previous experience of working in the community and felt they had been 'thrown into it':

it is quite a responsibility when you go into people's homes you know you have to deal with [a] whole different set of challenges so to speak because I don't know enough about the systems here

The same new recruit also pointed out that they had 'done 5 chartered flights' to Guernsey and had experienced a number of acute emergency situations since taking up post in Alderney.

The new recruits in Alderney valued the education and training available to them to help them prepare for their role. They also mentioned the supportive nature of the team especially during emergency situations and the ability to make contact with key specialists in Guernsey when seeking further advice.

The long-serving Alderney participants provided further insight into the experiences they faced in practice and how they coped with the situations they found themselves in. One of the participants highlighted that in the main their role involved providing 'basic' care to older patients residing in the 'long-stay' facility in the hospital. The other aspects of their role was very varied and included dealing with people with traumatic injuries. This participant was able to cite a number of incidents which were challenging to deal with including a recent fatal car crash and a young child with a very serious injury to their foot. They went on to explain the fact that the emergency care was provided by the on-call GP and nurses who were not A&E trained, limited their ability to provide treatment to these patients other than to 'stabilise and get them off' [to Guernsey]. However this participant did point out that the training they received 'is better today' and the use of scenario's had particular value in helping them to deal with emergency situations.

The other long-serving Alderney participant was both a RN and midwife and had the additional challenge of maintaining competence in both roles:

we are fortunate that we do have the opportunity to work on [Guernsey], our supervisor of midwives is based in Guernsey I probably would have been a lot more experienced midwife at this stage but I find that being on the dual role register is a good asset to me I really wanted to maintain both registrations

This participant undertook placements in Guernsey to maintain their skill set within the field of midwifery. However they recognised the challenge of maintaining the skill set to meet the needs of the clients associated with their nursing role:

we got to meet the needs of every patient on this island and some of them are very complex needs....

They also pointed out how difficult it was to maintain their skills when they meet patients with certain conditions and problems very infrequently. In situations like this, the RNs in Alderney rely on the specialist in Guernsey to support them in developing the skills they need to care for the patient as well as help develop a package of care to meet the patient's needs. This participant stated

I may have only nursed one or two ... patients with a really rare condition but that can be a chronic condition over maybe five years so it is getting the resources for that particular patient to meet their needs is the key thing to working in Alderney

The longer-serving participants in both Islands appeared to have accepted that the scope of their roles would be broad. Some had held a number of different posts within the organisation and as such had exposed themselves to a range of opportunities to develop skills. Participants had also been sponsored to undertake long courses to develop specific expertise.

personally I have been able to do a masters degree that I was funded from here which was excellent I might not have had that opportunity to do that when I was working in the UK even though in ... geographical terms it was a lot easier to get there,

For some participants who had been in post many years and seen the service grow and evolve and, as such, recognised the impact this had on the staff and the roles they hold in the organisation. A good example was critical care:

they didn't have an ICU patient very often because they flew everything out everything got flown off island

Critical care also provided the day surgery and post-operative recovery services at that time, which came as a surprise for this participant when they took up post.

I was told that I [had] got interviewed for ICU ... there was no mention of recovery and day patients and I didn't have a clue about recovery you know so that was a shock

Over the years the critical care unit has expanded to include surgical and medical high dependency and Intensive care. The participant stated that this created problems as new recruits were rarely qualified in all aspects of the service provision. They usually take up employment being able to care for a patient with a coronary problem but may not be able to care for a ventilated patient and vice versa.

There is an issue with discrepancies between the scope of practice of the role people are initially appointed to and the skill set they have. This can result in the individual presenting with a skill gap and/or having skills they are not able to use. Whilst there appears to be a commitment to staff development there is some question over how this is managed to ensure high quality learning takes place. In addition identifying and tapping in to the range of expertise available on the Islands may go some way to fill knowledge gaps as well as enable individuals to maintain their skill set.

Professional accountability - the specific challenges.

When comparing the narratives it is evident that the issue of professional accountability was high on the agenda of the new recruits. The main concerns were around standards of practice and the degree to which it conformed to national and regulatory standards. Their concern was further compounded by the lack of a legislative infrastructure to support specific aspects of practice. One participant identified the problem with the use of covert medication:

I suppose the legal system is different here as well isn't it [pause] I still do it to my standard and I put care plans in case to cover the medication we are giving out but to me you wouldn't be allowed to do that in the UK without the consultant or consulting the family first and documenting it in the medical notes but there doesn't seem to be any consulting with anybody here

There was also concern about the use of verbal orders as a form of remote prescribing during out of hours. If a patient's condition changed, the doctor would be called which could result in the nurse accepting a verbal order for medication over the phone. The reaction by new recruits was one of shock:

there are things that are not NMC guidelines here and it's kind of like OMG I can't do that that's not right, things like you can do verbal orders I don't really agree with it but I have done it

Although the new recruit felt that taking verbal orders was unacceptable, there was a prevailing norm that it was 'OK for the nurses to do this'. This also extended to a doctor giving a verbal order for a do not resuscitate instruction for a patient who was dying. The participant relaying this incident stated:

I don't know the doctor because it was my first few months I don't know the patient so I said I was not happy to take it so she asked to get the number one bleep [the] two of them took that decision of not to resuscitate the patient, that patient died that night

It is clear from the narratives of the new recruits that they were able to identify practice which was unacceptable, it is also apparent that in time, the new recruits begin to reluctantly accept it as demonstrated below:

at the beginning it was quite weird, the verbal orders for example, because we don't have junior doctors so we [had] verbal orders to accept....but it doesn't work so bad I think..... [but] sometimes we don't need just a verbal order we need them to come to see the patient and decide what to do.

One of the long-serving participants mentioned the issue of verbal orders and how they felt about them when they first joined the organisation:

I remember the first time somebody said to me to take a verbal order for a controlled drug and I was thinking what surely a doctor has got to come in and assess a patient if they need morphine or something and they didn't and I was saying what if they say that they didn't say you'd get somebody else to listen in on the phone and stuff and literally write down verbal order taken and I remember thinking that is a massive responsibility particularly as a newly qualified nurse

They went on to explain that in the past the hospital in Guernsey was small and served by the GP practices; the medical specialists were part of those practices. This

participant felt that they knew the medical staff well and the team was tight at that time influencing their perspective of taking verbal orders:

I did accept it actually, I just thought well this is how it is, this is why it is different

Another key challenge for all participants was maintaining confidentiality in a small community:

everyone knows everything about everybody, there are 4 patients in a bay and they all know one another comparing notes, that can be a bit awkward when you ...are trying to keep things private.

The narratives indicate that maintaining confidentiality was particularly challenging for the long-serving RNs based in Alderney and less of an issue for the new recruits based in Guernsey. This is possibly due to the smaller population and the increased likelihood that people will know the long-serving staff who work in the hospital as demonstrated below:

you always get people in town when you are shopping because they know you work here, stop and ask you, oh you have got so and so in what's up with them, and you have to think of a polite way of saying I am sorry but [laughs] it is nothing to do with you and you get that a lot, you do get that a lot.

As demonstrated above the longer serving participants had developed strategies to cope with protecting confidentiality in much the same way they protected their anonymity.

Finally the longer serving participants were concerned with the resources and infrastructure needed to provide a quality service and the implications when these were not in place. This reflected their roles within the organisation which had some degree of managerial function and as a consequence they were accountable for the resources and service provision in specific areas of the organisation.

Policy and legislation

Island infrastructure -politics legislation and geography

Participants identified challenges associated with the Island infrastructure; these were political, legislative and geographical in nature. The narratives indicated that the new

recruits were mostly concerned with the geographical issues which impacted on their choice of accommodation, the cost of living and ability to travel away from the Island. The new recruits in both Islands raised the issue of accommodation. In Guernsey, the housing laws that are set to control immigration and population growth restricted the RNs to living in HSSD accommodation or the highly costly open market. The alternative was the issuing of a time limited housing licence to live in Guernsey for 5, 7 or 15 years; this enabled the licence holder to buy or rent local market accommodation. The majority of new recruits were living in HSSD accommodation; they provided a very mixed response in terms of satisfaction.

One participant was living in a converted house with their partner but was waiting to be transferred to a purpose built block of self-contained units. They described the accommodation as being unsuitable for a couple:

we are taking two rooms, two single type rooms and mixed and matched the furniture and arranged it but it isn't very appropriate....your TV area has a sink in the corner you know this kind of thing, I can't wait to go home now and lie on the couch and put my feet up because ... you have to have it to sit on first

Another participant concurred with this view of this type of accommodation:

... the accommodation I am in at the moment .. is not suitable for long termthere is one kitchen for 15 people there's no sound-proofing between me and the room next door, there's literally none,

Paradoxically, one participant initially opted for the purpose built block of self-contained units but moved to a converted house because they were unhappy:

...I lived there for 2 weeks and felt very isolated because it is little self-contained flats. I didn't like it but then I moved into one of the other nursing houses in a shared flat with other people in the same building that I work with.... since then I have been very happy I don't get home sick

However another participant had been employed along with their partner and particularly valued the positioning of the new accommodation block which is in the hospital grounds:

I don't see no one during the day... some people I have never met or seen in the corridors, but I quite enjoy [living] there, the flat is not big but it is quite nice, for 2

it is big enough, its near the hospital, when you are off on nights its good just go straight to bed,

One of the participants was housed in a converted hotel, along with 19 other people including 3 from the same country of origin. This person valued the company and friendliness of this environment:

we talk to each other we sometimes [cook] communal dinners, we get together and someone does the main meal, ..., I usually do the desserts...

The participants' responses indicate that there was a wide range of HSSD accommodation with the potential to provide something for everyone, however one participant felt more could be done to meet the needs of the employee:

.. the hospital has lots of accommodation that a lot of the time is [available] and they don't tell anybody about it. It would be very easy to have a newsletter once a month to say this accommodation is [available] and people would be so much happier if they thought they had a choice. Even if they didn't utilise that but if they thought 'oh if I could move to here, I like that area', but we [are] not be given that choice

The participants issued with a housing licence were initially satisfied with the choice of accommodation open to them, especially with the grant they are given for the first two years of employment. However after two years the grant is no longer available resulting in the following situation:

my rent is now £1800 but the states pay £1100 towards that but only for the first two years so I am going to be moving from a nice two bedroom house to a one bedroom flat and paying £400-£500 more

This participant went on to identify further issues associated with the 5 year housing licence they had been issued with:

I am staying for 5 years so you will be struggling for 3 years and you can't put your roots down can't have children or anything as you are going to uproot them and your family after 3 years. Whereas people who haven't got a family can stay in the nurse's home for 6, 7 or 8 years and they are happy to do that because it is relatively cheap in comparison.

Only two of the longer serving participants lived in HSSD accommodation, the remaining 13 had either been issued with a 15 year licence or had married a person

who had residential rights. These people were more concerned with the cost of buying and renting accommodation and the impact this could have on recruitment:

well our house isn't a very big house and we had it valued recently and it is almost half a million pounds it is ridiculous for a very small house, great for us but not great for anybody else and if I was coming over with small kids again [that] would probably put me right off

The concern with the cost of housing extended to the general cost of living on an island that is not self-sufficient and heavily reliant on importing goods and produce:

the true costs of living really it's not really clear and it's hard to find so unless you are clued up I think that is why there is such a big turnover of staff because I just look at my outgoings which is £2100 a month, my salary I would probably have about £400 left so regardless of whether I get a housing allowance or not it's kind of like well in the UK my outgoings are probably about £8-900 including rent and stuff so gosh

A long serving participant added to this concern about the cost:

It is a beautiful island, because it is a beautiful island but you pay for it you pay for it in lots of ways, financially

There were also issues about the cost of flights when wishing to leave the Islands. Four out of the five Alderney participants identified this as a key issue, as one long serving participant stated:

The cost of getting on and off the island will always be a problem, the ... fares are extortionate.. I wanted to book a ticket the other day to go to Guernsey for next week just because I left it till [the last minute it was] £100

Another participant paid £300 to get to Scotland. The newly recruited Guernsey participants were frustrated by the lack of a direct flight from the Islands to their intended destination, resulting in additional cost for people originating from Scotland, Ireland, and Portugal.

it is difficult to get here because they have to get 2 flights to get to Ireland there are no direct flights so that makes it difficult for my parents but my sisters and nieces and nephews come

The political and legislative infrastructure associated with the Islands also gave rise to specific challenges. This was particularly true for the long serving participants who were working in more senior posts and demonstrated greater awareness of the political and legislative challenges impacting on practice.

One of the participants called for the development of an immigration policy and more work to address the widening gap between the rich and poor on the Island. The latter was echoed by another participant who admitted to not realising that the gap existed until they had been in post for a long time. Other areas creating challenges included the lack of legislation to support people with a learning disability or mental health problem as there is no mental capacity or discrimination legislation in place.

The smallness of the community also resulted in politicians being more involved with the decision-making associated with the development and provision of new services. Members of the island community can readily contact their political representative to discuss their individual case as demonstrated below:

we might not be in a place to provide a service but families may desperately need it the politicians get involved they go and influence the board and the board say you have got to do it ... so then you are left in a situation where you have been completely undermined and disempowered and you have got to provide a service without any more resources ...

The longer serving participants on both Islands were also challenged by the political decisions related to the economy of the Island and the pressure to transform public services and contain costs. Whilst this raised concerns that this would result in the cutting of services and reduction in resources, there was also a realisation that the current service provision was not sustainable.

The Island experience - in the eye of the beholder

The new recruits were able to provide insight into the challenges facing people who decide to move to a small island community and the type of strategies they have developed to cope with them. The long-serving participants provided further insight into these challenges, both in the way they have changed over time and the ways they

have learnt to deal with them. These challenges were related to the environment, the pace of life, the amenities, the culture and the lack of anonymity.

The Island environment was an attraction for many of the new recruits in both Islands. The relatively low crime rates, the mild weather, the sandy beaches and scenery seemed to have a positive impact on their quality of life. People with families particularly valued the fact that their children could grow up in a safe environment which was close to the sea. One new recruit stated:

and there is so much here for a little place there is so much to do out here ... and a lot more things that you would normally only do on your holidays ... you have the beaches on your door step it doesn't take long to get to any beach ... the beaches are lovely there are lots of little get a-ways it is like a little tropical island in the summer here, it depends on what time of year you come you should get them all coming over in the summer [laughing]

Conversely, others felt that the environment provided a number of challenges; the fog, rain and lack of summer sun was highlighted as an issue. The fog was a problem when planning air travel as demonstrated by these statements from a new recruit based in Guernsey in the first instance and one based in Alderney in the second:

so to begin with it was oh god get me off this island [laughing] yeah because you do when it is foggy when it's not nice

my family saying oh we will come over but I am saying it is not just a question of you [coming to] visit me, if there is fog you won't get across so you can plan your whole weeks holiday and never come across to the island

The longer serving participants were less concerned about the weather, although those based in Alderney highlighted the problems of transferring patients to Guernsey when faced with fog and rough seas.

There was also some surprise amongst the new recruits around the volume of traffic in Guernsey which resulted in long commutes to work, despite the short travelling distances:

one of the pros that was touted about Guernsey was that the commute would be five minutes rather than an

hour but it isn't going to be depending where you are living and depending at what time you are going to start work but you could have a 4 mile commute and it can take you an hour and if you are starting at 9oclock in the morning

Despite the smallness of the Island, some participants found it difficult to navigate around the Island; this was further compounded by road closures and diversions. Others felt a sense of isolation and loneliness due to the geography of the Island and the lack of contact with friends and family:

it felt that we were starting all over again and knowing that all my friends and family were in England and not that far away it was a bit have we made the right decision here and maybe we should just go back to London and it would be easier

Whilst the longer serving participants did not feel the same sense of isolation, they were aware that people who are new to the Island can feel 'cut off'. On a more positive note some participants commented on the community spirit which has given rise to various events which take place on the Islands, as well as the opportunities to engage in hobbies and other past-times:

the community spirit of the place there is always something organised just now, there is the harbour carnival, or we have a dog, there is a dog show in town or there is the hill climb,

The longer serving participants, highlighted the importance of engaging in local activities in order to make friends outside of the work setting. Without exception all these participants had engaged in Island activities and had developed social networks, which could account for why they feel less isolated.

The slower pace of life was seen as an attraction for many of the new recruits, however there was also a feeling that the pace of life was a little too slow and quiet. A number of participants were disappointed that the shops closed at 5pm and for those who had already 'done a winter' highlighted how things slowed down even further during the winter months. Participants were also disappointed by the lack of amenities on the Island, especially certain supermarkets which sold cut priced food. This new recruit felt that Guernsey was like Ireland 20 years ago:

Sunday closing, no late shopping and when you finish a day's work instead of going home and sitting in those

dreaded rooms wouldn't it be lovely just to pop into town and have a walk around the shops

The longer serving participants were less concerned about the pace of life. One of these participants explained that they had just got used to the slower pace and learnt to 'scale down' their expectations. However they felt these gaps in the Island offering were filled by other things:

there are bits of island life that are stunning that you wouldn't get anywhere else I remember my girlfriends coming over, we went to Herm Island and we sat on shell beach and one of them said do you know we could be sat in the Caribbean here

In terms of Island culture, the new recruits felt that the Islanders were friendly and helpful, most were welcoming and accepting of them. Paradoxically some participants indicated that there were racist tendencies amongst the populace and the presence of a social divide between the local people and those coming into the Island. They also felt concerned about the attitudes held towards people with mental health problems:

I wouldn't say frowned upon but it's not viewed as serious as it really is and I feel that is really unfortunate and that alone is frustrating

Two of the longer serving participants supported the view that racism existed in the Guernsey community, one described how 'dumb-founded' and 'gob-smacked' they were by it. In addition one recruit took exception to a comment made in the media about the recruitment of staff from the Philippines:

they say it's being compared to white slavery which is a bit off I think

The biggest challenge experienced by the participants was the lack of anonymity. This appeared to be more problematic for the long-serving participants as they knew more people than those new to their role, although the new recruits found it 'quite strange' to meet the people they had cared for outside the care environment:

I was having a drink and this woman I didn't recognise just shouts across the bar 'oh you were there when I had my operation'.

when you are out in the supermarket and things and someone will be like 'nurse nurse' ... I didn't have that in London.....It makes you feel a little bit vulnerable at times

This vulnerability is further exemplified by the experiences of the following new recruit working in the field of mental health:

I was tapped on the shoulder when I was having a drink in a bar by one [service user]; that made me feel extremely uncomfortable because you are always being, I suppose you are always being observed really

you receive one or two inappropriate comments in work in the sense 'I will see you out'... I think when you are in a unit in London you are thinking you will never find me but now when you hear that in your work place

The long-serving participants felt that their privacy was invaded during their 'off duty' time and that service users would often cross the boundary and ask inappropriate questions in the public domain:

because people are not very boundaried in Guernsey so I would have parents I can think of 2 or 3 in particular who would come up to me in the street and say oh I want to book my child in for respite next week and I would say but its Saturday it's my day off and you need to ring me at work or they would just launch into a big [pause] tirade about their child in the middle of the high street and I would be saying you know I am really sorry there is not a lot I can do

Another long serving participant in a managerial role explained how events that had taken place in their personal life had impacted on their professional one as a result of the media interest the event attracted. The people who worked with this participant had read the local newspapers and so were fully conversant with the incident concerned; this participant said that they found this difficult to cope with.

This comment aside, many of the long-serving participants had developed coping strategies to deal with the lack of anonymity and the closeness of their client group. These included avoiding certain venues, keeping their head down to avoid eye-contact, not sharing their personal life with clients, negotiating and agreeing boundaries with clients and being assertive in managing those boundaries.

At the same time the participants suggest that the privacy of potential and actual service users have been compromised due to the 'knowledge' that Islanders have about each other. This knowledge can impact on the care that service users receive, as well as place RNs in professionally difficult situations both within and outside of the

care setting. This issue was especially challenging for the new recruits working in Alderney:

they sort of know them from the community they know all about their private lives their social lives and then they obviously have opinions and strong feelings about what they think about how that person isliving their life and I think sometimes when those patients come there is a lack of impartiality sometimes ... particularly patients with psychiatric problems

One long-serving participant described how they coped with becoming increasingly 'knowledgeable' about their client group. They used the example of caring for a specific client over a 10 year period which had resulted in a number of long hospital admissions:

every day I treat her as though she is newit's this admission ... this is different than last time although I can't take it in isolation as there is history that is valuable .. for me to know and there are things that happen now that I can predict behaviours very quickly and very easily we have this set of symptoms and this is what we are working with

All participants faced challenges with Island life, some of these changed over time, others disappeared or were dealt with through the development of different coping strategies. This will be explored further in the analysis of individual stories.

Organisational Infrastructure

Health and social care systems - differences and similarities

The health and social care systems in place in Alderney and Guernsey created a number of challenges for the new recruits even though some had a range of experiences behind them including working in private medical care and smaller community settings. The majority of the new recruits were from the UK and had worked in the National Health Service.

The key differences included, the lack of resident doctors in the secondary care setting, the private primary medical care system, the lack of specialist services on the islands, the breadth of the service provided by departments and the integration of social care with health.

One participant was vociferous about the lack of infrastructure to support the services they were responsible for. This included the shortage of suitable facilities available for 'looked after' children. This respondent described a particular scenario involving a group of siblings:

they shouldn't be on the same site as offices it shouldn't be next to the secure unit it should be a nice house out in the community if we put those kids in a nice house in the community they would think they had died and gone to heaven

This individual was also concerned about the skill mix in their service and ensuring that the staff underwent the training and development needed for their roles. There was also some concern with not having the resources to care for children with complex needs. However they did go on to cite an example of where they have used volunteers to help support the care of a child in Alderney, which together with input from the hospital staff had proved successful.

Another participant identified the challenge of providing a service when caring for a number of people who need a member of staff with them all the time. This close observation had impact on the delivery of care for the remaining people on the ward:

you have got 4 people on level 3 or 4 supportive obs, who need a member of staff with them all the time, how are you how are you offering evidence based therapeutic interventions things that aren't medication driven to support those people 24/7 for weeks and weeks and weeks ... when your own work force is becoming exhausted because you are trying to cover every shift you have still got another 16 people on the ward that need input and they are getting nothing because your resources are with these people on constant obs,

The key issue for this participant was establishing the correct skill mix to reflect the usual demands of the unit, whilst having a plan in place should those demands increase.

The experience of working in a different system has been captured by other themes. However a longer serving participant felt there were particular challenges with the

private primary care system when attempting to meet the needs of the clients in the community:

here where people have to pay particularly for a home visit you can't well you can suggest that to a person but actually that is quite a big ask erm when they then have to pay a lot of money for somebody to come out

This dilemma was further supported by a new recruit, who stated:

I am quite used to private medicine so I think people coming from the NHS would find that really hard when you go to see a patient and you know they need to see a Dr and they will say no I can't afford for the Dr to come out and I can imagine that could be quite hard

The RNs from countries outside the UK also commented on the cultural differences associated with caring for the service user. The Portuguese nurses were surprised at the level of literacy of the older generation accessing the service. This differed largely from the older generation in Portugal where only 1 in 10 was able to read and write. One participant stated:

I was very surprised when one day I saw one of my patients 88 years old lady working on her laptop listening to music , I was so surprised because in Portugal elderly people, most of them don't know how to read. Some of them don't know how to write

They commented on how this influenced the care they provided especially in relation to the provision of information. They felt that the older generation in Guernsey were able to better comprehend the details of their care. However there was also a feeling by another new recruit that people accessing the services in Guernsey had certain expectations which differed from their own:

I think sometimes people don't recognise that they are in a hospital and we are nurses we are not like the handy lady they have at home and they do everything for you. We are not supposed to do everything I think. It was quite difficult in the beginning, go to the kitchen and get a cup of tea or two and give it to patients and relatives, it was like I didn't come here to do this, it was quite strange

The cultural differences were also recognised by the longer serving participants who originated from outside the UK. One of the key differences for one of these participants was the role of the RN in the delivery of personal care. In their country of origin this

would usually be provided by the relative but they had to adjust to the fact that this care was considered to be part of the role of the RN.

The new recruits were faced with a health and social system in the islands which differed from the structures they had been used to. This is further compounded by the cultural differences which can impact on the way they provide care and the expectations for their role. The longer serving participants expressed their frustrations with the health and social care infrastructure which at times was not fit for purpose.

Policies Guidelines, standards and protocol

The new recruits were challenged by the differences in the policies and guidelines used in the Islands, especially those who had used UK national standards whilst working in the NHS. One recruit has been used to using both NICE and SIGN guidelines whilst working in Scotland and was surprised that it was considered acceptable for doctors in Guernsey to deviate from the protocols and set standards. Another new recruit stated that at times care could be left to 'drift a bit' because the NICE guidelines were not being followed and they found this frustrating. One of the longer serving participants went on to point out how the lack of agreed standards has resulted in variation in the way the consultants work which had impact on the range of resources needed to support their different approaches to practice.

On the other hand one of these participants felt there was some merit in having these differences:

when I had my interview they said they looked to the NHS to see what policies and initiatives they introduce and then they basically pick and choose what works and what doesn't work well which is good because a lot of the time things are put in place which aren't really beneficial

This was also supported by the long-serving participants who stated that national standards did not fit with the Guernsey system and that 'they had no direct bearing on what goes on here'. Another participant suggested that Guernsey should be looking further afield and benchmarking against standards associated with healthcare systems that are working well and not always look to the NHS.

The participants from Alderney highlighted the problems in providing care to a national standard with the resources they have available on the Island. One new recruit was concerned that patients returning to the island for rehabilitation did not have access to the same amount of therapy they would have received in the UK or Guernsey. This was further supported by a longer-serving participants who felt that patients should receive the same level of care even though they live on an isolated Island, however the resources to support this were an issue. The other longer-serving participant from this Island felt that the emergency care they were able to provide in Alderney was at times judged as 'not good enough' by the team in Guernsey. This participant went on to state:

I mean in Guernsey she had the anaesthetist the orthopaedic the A&E consultant the paediatrician a specially trained A&E team all working on her we had me and a GP and an auxiliary and you know do you think they really know, you know what is involved in something like that here. I mean you do your best and it is never good enough sometimes

It appears that the team in Guernsey were expecting the staff in Alderney to provide the same level of care regardless of the fact that the level of resources available in Guernsey surpassed those in Alderney. There seemed to be a lack of understanding of the context in which the Alderney team were working.

Finally, one of the new recruits from outside the UK was concerned about the use of the incident reporting systems in place within the organisation. This was a system they were not familiar with in their own country. Whilst they saw some merit in the process of reporting incidents which led to patient harm, they thought that other errors could be dealt with by communicating with the person concerned. There was a feeling that completing a form without investigating the circumstances in which the incident occurred, gave rise to conflict between departments. This perspective was reinforced by a participant in Alderney who also voiced a concern about the incident reporting process and the tone of the investigation process:

I had this interview I came out thinking I had practically committed murder it was awful

This theme highlights some of the issues the participants had with applying national based standards to the island context where resources are limited. At the same time

there appears to be some issue around the way two of the participants viewed the incident reporting system. The picture they provided reflected a culture of blame rather than one of learning.

Multi-disciplinary team - challenges and achievements

The participants provided an over view of the challenges and achievements of the teams they found themselves working in. These included issues related to communication within and outside of the care environment, having access to available expertise, communicating with the medical staff, and the use of agency staff.

Small teams and close geographical proximity of team members enabled timely referrals and quick responses to meet the needs of patients and clients, especially with respect to social care provision:

I think it makes our job a lot easier because to be able to speak to a social worker to be able to speak to them here and have a face to a name whereas in London it was all done over telephone or email it was so much harder to get something but the fact that we work in the same building as the social workers as the OTs, as the carers is just great because any concerns that you have about a patient or anything you want to do you can just go and speak to them

They also highlighted the importance of technology in facilitating communication. This was especially welcomed by the five participants from Alderney, who used electronic modes of communication to liaise with colleagues based in Guernsey. One longer serving Alderney based participant stated:

...the cameras come in .. taking pictures of wounds and everything has made a big difference, we can email them down [this has] made such a difference for us certainly for me

... we can send those x-rays straight to Guernsey and we can get advice on how we can deal with that straight away that is just amazing absolutely makes our life here so much easier things that you would have constantly worried about before, you can get the specialist to see and you can get the information back; that has been an absolutely amazing breakthrough

The above statement captures this participant's sense of relief that they have the ability to access the advice of people with greater expertise despite being geographically distanced from them. The narratives suggest that the Guernsey participants were not regularly using technology in the same way as their Alderney counterparts. It could be assumed that this is due to the availability of the expertise which exists on the Island.

Another challenge facing new recruits regardless of country of origin, was the ability to communicate effectively with the medical staff who support the health and social services on the Islands. A number of issues arose from their narratives including a perceived power imbalance in the relationship between RN and Medical professional as demonstrated below:

...the psychiatrist is happy for you to dish out medication but when it comes to opinions or when it comes to any sort of suggestions they are not taken on board as they would have been in the UK... psychiatry over here is viewed like the priest of all times,

...you need to lose that psychiatry up there and bring everyone into teams...

.....and I think the nursing team needs to be more assertive and have more input with the consultants but when doesn't the nursing team need to have more input.

This is further supported by another new recruit's experience of working with the Consultants and challenging them when they don't conform to national based standards:

I think they think they are better than us..... they probably do know better but there is never an explanation to say well this is why we are not following it.....

However this participant goes on to state that the absence of resident junior doctors requires the RNs to make more clinical decisions especially determining when to alert the consultant that a patient needs re-assessment. This has required a different skill set to ensure that they have evidence available to provide an accurate clinical picture and to convince the doctor that they need to come in to reassess the patient especially at night:

....there ... is not always a doctor on the ward so you have to really use your initiative a bit more sometimes

*and know when it is appropriate to get them in
whereas in the UK you might have junior doctors
around, you can just say oh can you come and have a
look...*

*..I remembered when I started working I was asking a
colleague if you want to speak to the doctor what do
you do, they said open the computer get the blood
results ready get the x-rays ready get your
observations chart and everything in front of you before
you call..*

One of the long serving participants reiterated the need to have good communication skills when calling the doctors, ensuring that relevant data were at hand before calling them:

*you had to be confident and competent speaking to the
doctors because there was no point in phoning and
saying can you come out to see Jo Bloggs they are not
well you had to say they are not well and their
temperature is this, their pulse is this their BP is this
and that is abnormal for them or their BM is whatever...
you had to have all that information to hand so I think it
made you more ... confident and competent
practitioner*

The RNs felt that they were filling a communication gap which existed due to the absence of junior doctor and therefore had implications for the skill set they needed for the role.

The other issues that both new recruits and long-serving participants identified as a problem was the turnover of staff and the number of agency staff in their place of work. One new recruit had 5 agency nurses working in their area which they found changed the team dynamic:

*so it changes the dynamic because if you know
everybody you know their skills straight away you know
this person is confident with a vent or not this person is
comfortable with that, but when you have an agency
and you have multiple agency nurses, I am not saying
it is a bad thing they do a job that is absolutely needed
but if you have 2 or 3 people on a shift where you have
7 people that is 50% that you don't even know if they
know how to use a ventilator*

The fact that agency staff were being paid more than the permanent staff also impacted on the team dynamic. Another new recruit felt that having an agency nurse in their area was 'more trouble than it was worth':

I have no doubt that at some point he will leave and then I know that his cases will have to be taken up

One participant who relied heavily on agency staff to support their services, felt that some agency nurses settled and made a valuable contribution to the team, whilst others felt that they would be deskilled in Guernsey and left by the end of the week. It is apparent that the presence of agency staff, together with the staff turnover can impact on patient continuity and team stability. At the same time it is evident that agency staff can be useful, especially if full-time and employed for the long-term.

Sources of support

The participants were able to identify a number of informal and formal forms of support available to them within the organisation. This included induction programmes, preceptorship, managerial support and supervision. All new recruits were expected to attend an induction programme, the Portuguese and Filipino nurse had an augmented induction in the form of additional study sessions for the Portuguese nurses and the Filipino nurse underwent an adaptation programme.

The new recruits had received some form of corporate induction before they commenced their employment in the work place. Although there was some debate around the relevance of the programme, the participants seemed to value the opportunity to meet other people and obtain support. The following participant summed this up:

*I did induction for three days and one of the guys on induction was a guy called S and S was from G and we got talking and he said what do you think of the accommodation, it's like ***** and so is mine so it was good to have someone to moan at so we did the induction and if it wasn't for the 2 of us being here at the same time, I don't think I would be here.*

Induction was also seen as a good opportunity to share information related to living on the Island, such as the best place to buy food and how to register a car. However one longer serving participant felt that the induction should be more service specific as the

staff needed separate induction on taking up post in their chosen area of employment. This was particularly true for the participants working in Alderney.

In addition to corporate and local induction, staff were offered varying lengths of time working in a supernumerary capacity; in one place the staff were supernumerary for one week in another it was two. The ability to offer this type of support to new staff was dictated by the staffing levels at the time. The longer-serving participants admitted that staff sickness or other factors resulted in the new recruit being included in the 'staff numbers' quicker.

In some cases new staff had access to a preceptor to support them during the first few months of their employment. They also have a structured competency pack to support their learning in this time frame. In addition there are practice development leads across the organisation to further support new and existing staff in their roles. One of the new recruits stated:

if you have good preceptorship initially then I think it is fine and I think the support throughout has been good anyway

It is difficult to determine from the narratives whether this form of support was available to all new recruits taking up post in Guernsey and Alderney and whether there was some consistency in the experience. One area where the experience of new recruits was variable related to level of support they received from their line manager. This ranged from a manager who phoned one new recruit to say they were doing a great job through to the following scenario:

I just think the manager I had at the time when I first came here he was OK to begin with but because of the questions I was asking about things I was then sort of worn down a little bit so

Finally some staff had access to clinical supervision, especially if they worked within the field of mental health; some were provided with external supervision. For those working outside that field, access was variable with staff relying on the ability to talk to colleagues or peers on a more informal level to discuss issues related to their practice. One longer-serving participant stated:

I think there is a lack of support supervision for ward managers up erm and I think trying to look at a balance we are bad at asking for it as well we assume that

*nurses are very good at we'll cope we'll muddle through
erm and with the best will and intentions things have
been set up BUT people go off sick or there is an urgent
meeting and then you realise that it has been six
months and you haven't met*

This perception of being seen to be coping was echoed by one of the new recruits who had become aware of some of the support that was available to employees including counselling:

*you would be afraid to look for support because you
don't want to show weakness if that's the right way to
put it*

This participant went on to suggest that new recruits to the Island should be made to feel that it is 'natural and normal' to access help to deal with issues related to locating on the Island and dealing with Island life.

This themes highlights that there are a number of support mechanisms available to new recruits, and some of these strategies are available for longer-serving staff. People working within the field of mental health have access to supervision but this is less integrated into other fields of practice where more informal modes of supervision are in place.

Individual context: Characteristics and background

Communicating effectively - linguistics

This theme is concerned with language and the ability of the participant to convey messages which are understood as well as understand the messages they are receiving.

The participants who did not hold English as their first language provided insight into the challenges they faced when communicating with other team members. This was especially true for the three new recruits who were still mastering the language. One participant spoke about their experience during their induction programme:

*..' all the sessions [were] in English which was
quite difficult at first because some people speak quite
quickly and with different accents so I [didn't]
understand a word that they [said]..*

Another described their struggle with the language and the impact this could have on their ability to practice safely:

'...my first worry is all the patients and I was kind of scared because I was afraid that I could understand something wrong or do something wrong.....'.

This participant also found the different accents they encountered added to the challenge, they went on to sum up the first month of employment as being exhausting. Despite these challenges the participants had developed some coping strategies. One focussed on the benefits of learning English in order to progress in the world of academia and gain a higher degree. Another set goals to achieve so that the steep learning curve became more manageable such as 'giving verbal handover', 'memorising' medication names' and just 'thinking about the basics in the beginning'. This individual considered talking on the phone as being a 'victory' as it was something they initially wanted 'to run away from'.

One of the two longer serving participants who held English as a second language provided further insight into the challenges they experienced with the language. This included translating from their mother tongue to English:

...for example if I say turn the lights off erm in [own language] it's like kill the lights, obviously that is not the way you do it [laughs]....

This participant also identified the need to be politically correct and culturally sensitive when speaking to people from the island and how that might differ from their place of origin:

...because at home things like (my husband notices as well) if you ask people their age or you say like oh you put on weight they don't really care but here...

These experiences highlight the complex nature of learning a language and its nuances which can affect meaning and the message being received. The fact that both of the longer serving participants had been employed for at least 5 years and had married 'local' people may have helped them to learn these linguistic subtleties. Furthermore these people were part of two larger cohorts of staff recruited at the same time from the same countries. Many of the cohort had since left the Island reducing the opportunity for these participants to revert back to their native tongue; something they tended to do when socialising with each other. This aside it is evident that the

language barrier is a problem in the initial stages of employment. One of the new recruits suggested that further support should be made available in the form of English language lessons.

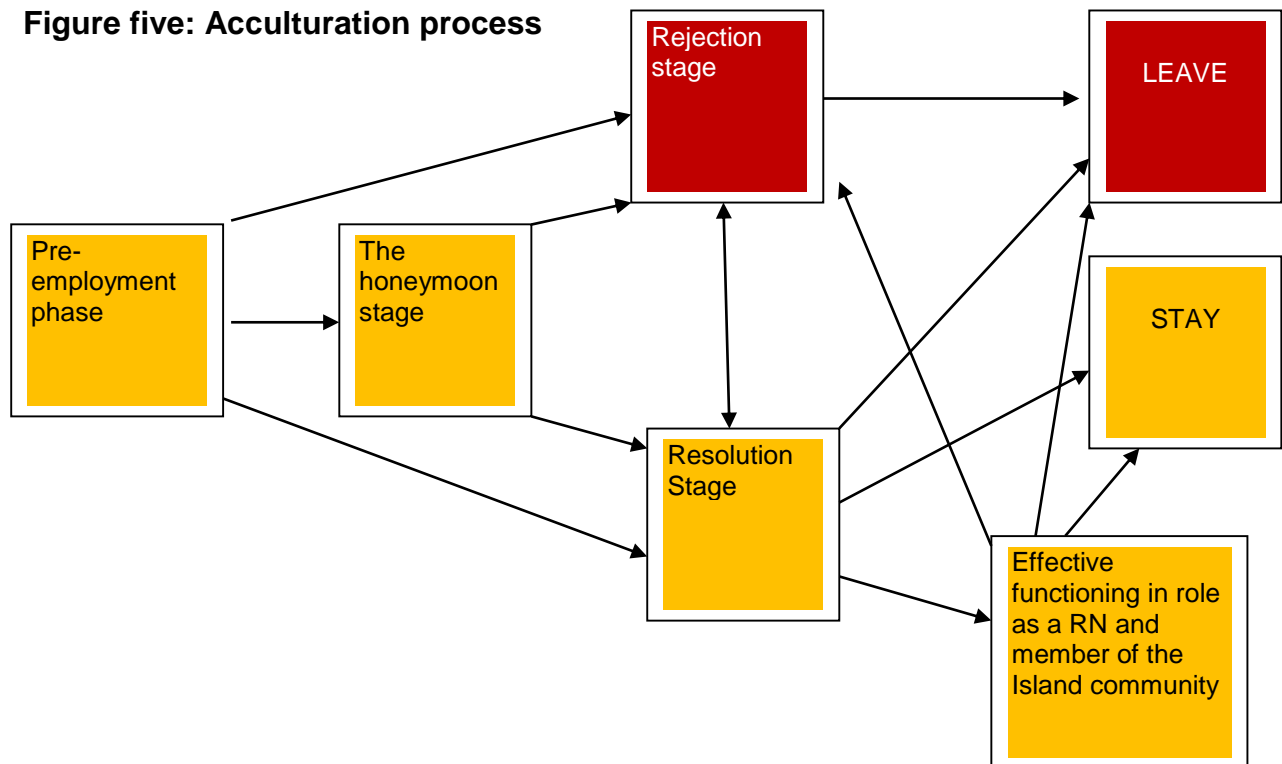
Acculturation - a journey without end

This theme encompassed the remaining four identified themes which included the experiences before island life, island life - the attraction, great expectations - the match with reality and coping with island life. On examining the narratives it was apparent that participants had varying experiences of the acculturation process which resulted in a number of different outcomes. Whilst it is evident that this experience would be shaped by the factors highlighted in the themes discussed so far, the characteristics and background of the individual appear to have a key role to play in the process.

On examining the narratives of the participants it is evident that the participants go through a process of acculturation which could culminate in them either staying on the islands or leaving. In order to gain a better understanding of this process, the stories of 16 participants were more closely analysed by considering their transcript as a whole entity along with any additional material they provided. As stated some participants put together written statements and imagery to capture their stories.

Figure five depicts the stages involved in the acculturation process. The first stage begins prior to the individual taking up employment on the islands; this is depicted as the pre-employment phase. During this phase the individual will have had a range of past experiences prior to taking up post, there would have also been a reason or motive which attracted them to the Islands. The participants would also begin to develop certain expectations of the role they will be employed to, their working life and Island life in general. On taking up post these expectations will be appraised against the reality of the situation and, together with their ability to cope with Island life, will determine whether the individual enjoys a honeymoon period, goes through a stage of rejection or reaches a stage of resolution.

Figure five: Acculturation process



As figure five demonstrates some participants will oscillate between the resolution and rejection stage, whilst others will go on to be fully functioning in their role as a RN and member of the Island community. The new recruits provide useful insight into the links between these stages.

One new recruit had experience of working in the Cayman Islands as well as London. Whilst this individual expressed the disparity between the experience of being based in a city and Island life, their experience of living in the Cayman Islands prepared them for the private medical care and the lack of anonymity in Guernsey:

I had it in Cayman it was exactly the same you would be on the beach in your bikini and you would see a patient

Another new recruit had been working in a small unit in the UK prior to coming to Guernsey and felt that this prepared them for the role they had on the Island. In addition this participant used to visit a friend from Guernsey, loved the island and had all intention of coming to work on one of the Channel Islands. Neither of these new recruits appeared to go through a honeymoon phase and in fact both had a short negative experience to begin with before moving swiftly to the resolution stage. One

of the participants initially felt homesick because of where she was living but this was resolved when she moved to different accommodation.

This same participant seemed to make a concerted effort to be part of the community by having a craft stall in the local market; they also made an attempt to 'get out and about' whenever they could.

I did hiking once but then it was really difficult because of the shifts and things. I have a craft stall.....In the summer I've been doing a stall at Saumarez manor and then .. a couple of Christmas fairs and I have done some sea front stalls as well: well it's something, especially over the winter, filled up quite a lot of time and it's just something we enjoy

Although this individual was going back to visit their parents every couple of months, this was becoming less frequent, indicating that the participant was fully into the resolution phase and heading quickly to the effective functioning one.

For others the pathway was not so positive. One participant was working in London prior to taking up post in Guernsey. After 6 years of early starts and late finishes in London, they decided to apply for a job in Glasgow and Guernsey; they opted for the Guernsey post due to their negative experiences with the NHS:

I was burnt out pretty much I was very very tired I wasn't offered any more than I was offered where I was and the politics behind the NHS was was was literally killing me erm and I suppose there was a lot of grey area within the NHS at the time there was no real security

Although this new recruit made a decision to come to Guernsey, they admitted that they were ambivalent at the time. It was evident from their transcript that they were not fulfilled in their job as they felt constrained with little prospect of development. In addition they were not satisfied with their accommodation and felt that they had little time available to spend with their partner. It could be concluded that this participant was stuck in the rejection stage:

it was a massive culture shock because everything was just pitch black and dark andoh I struggled, I struggled massively I struggled right up until I am still struggling if I am to be brutally honest I think I am still struggling with the whole of the island life,

One of the new recruits in Alderney, also struggled with Island life to begin with despite having had a holiday home on the Island for many years. However this individual seems to have moved into the resolution stage of the acculturation journey:

I found it quite hard because when I came here I came from a city and the first year I was here I felt very trapped and claustrophobic you know I just thought I don't think I am going to be able to stay here you know and I kept travelling off the island and for weekends or for breaks and coming back and I felt really unsettled and it wasn't until my second year here that I finally settled down to being here and I stopped going off the island actually which was really weird and I very rarely go off maybe once a year now

In terms of the honeymoon stage of the process, this seemed to be more evident in the stories of the longer-serving participants who started working on the Islands well over 10 years ago when the organisation was much smaller, critically ill patients were flown to the UK, staffing levels were 'generous' and the pace of service provision was less intense. The honeymoon period, seemed to be related to the individual experiencing less pressure in their new post compared with their previous position in the UK:

I will never forget because they were quiet compared to where I had come from because there was only 2 beds then....

it was easy to get up for work every morning there was no commute there was no ..traffic. I could go to work in my pyjamas and go home in my pyjamas because I lived in the nurses' home the other side of the canteen

I was pleasantly surprised it was a well resourced service bearing in mind my background was the institution where we had nothing I came here, money didn't feel like it was an object, the building was refurbished, .. we could choose whatever we needed erm half of the staff had a professional qualification and half didn't I had not experienced that in years, the staffing levels were generous,

The longer serving participants provided additional insight into the latter stages of the acculturation process especially with respect to the transition from resolution to the effective functioning stage of the process. The trigger point for some was the provision of a 15 year housing licence, which enabled them to remain on the Island for the rest

of their life. For others it was meeting a partner who had local housing qualifications which for some resulted in marriage and having children. Another factor was the individual making some form of investment, this could be buying a house or making a significant contribution to the local community.

I love walking out my front door and meeting my neighbours and talking to people ... I love [the] beach I spend nearly 3 or 4 times a week down there with the kids, hail rain or sunshine, we are down there skimming stones it reminds me of Ireland, it reminds me of the west of Ireland.

but I think you have to throw yourself in to the community and I do charity work and stuff like that you meet really interesting people ...

when we got the 15 year licence or applied for the 15 year licence we probably saw this as home at that point, but I think it is quite subtle that change

The change seems to be hailed by the acknowledgement that Guernsey or Alderney are now 'home' and the previous place of residence is not.

It is the bit when you are sitting on the plane and you are looking out the window and think oh it is nice to be home and you think oh gosh when did that happen

The acculturation process is not one directional and individuals can move backwards and forwards between stages in response to the dynamic interplay of internal and external factors impacting on the individual at the time. The longer-serving Alderney participant who had a negative experience following a critical incident seemed to have moved from the effective functioning stage to the rejection stage in relation to the way they perceived their role in the workplace:

I would be terrified to make a decision on my own these days because it is watch your back isn't it and you daren't do anything any more

Another long-serving participant also demonstrated tendencies towards the rejection stage if they did not get away from the Island on a regular basis, despite admitting that they have enjoyed their time on the Island most of the time:

I certainly ... feel a bit rock bound like you have got to get off the island just to get a dose of reality sometimes

This sentiment was shared by a number of participants from both groups, who perceived the ability to 'escape' from time to time as a coping strategy for Island living.

The feelings of claustrophobia are also felt when the weather prohibits travel off the Islands. Whilst there is perspective that being able to leave the Island is important to cope with Island life, paradoxically there is a general feeling that the housing restrictions impact negatively on the acculturation process as this instils a sense of temporariness in the position that the individual holds in the work place.

I've got 7 years so I am not thinking, you know, I do think, but in the sense .. the organisation ..can't think beyond certain time arenas because people are only around for so long, so I think that is a major unconscious/ conscious, issue that gets played out

This participant likened the holding of short term housing licenses to terminal cancer, in that asking people 'how much longer have you got' with respect to their housing licence is not a topic of conversation;

'you don't mention it'.

The longer serving participants in managerial positions have developed the ability to predict which new recruits are likely to stay and those that will go. One manager has refined the interview process to identify those people who are unlikely to cope with Island life:

We are getting better at interview so we can cut out the ones, we don't always get it right, but you know the ones that you think 'no they are never going to survive on an island they need their family support network right round them, they are too young for it whatever erm but like I say we don't always get it right but erm I think the interview process is better now for things like that

One of the long-serving participants on Alderney was also able to predict the intentions of the new recruit. They went on to state that the integration into Island life was very much a two way process which required effort on the part of the new recruits as well as the staff and community supporting them:

You normally can tell ... if they sort of join in social activities and make friends outside of work you normally and they are enjoying the work here; some just come and think what have I done and just leave again after a short space of time but it is a two way thing I think it is the individual as well

This section has brought together four themes which constitute the process of acculturation that the participants go through on taking up post on the Islands. The individual stories of the participants indicated that this process consists of a number

of stages with two possible outcomes. Whilst the factors identified in the previous themes had some influence on this process, it is evident that the characteristics, context and background of the individual also has a part to play in the direction that the acculturation journey takes. Arguably it could be said that this journey never ends as the individual finds themselves in a dynamic situation requiring continual adaptation.

This chapter has presented the results of the study which have included the final themes arising from the transcripts and the acculturation process relayed in the stories of the 16 selected participants. Whilst some attempt has been made to identify key themes, the differentiation between them is not clear cut; there is a deal of overlap and integration. At the same time the section addressing the acculturation process demonstrates that the experiences of the participants are individualised despite the evident commonality in the themes identified. The next section will revisit these results and analyse them in the light of relevant theory and other forms of research.

CHAPTER FIVE

Discussion

The following chapter will further develop the analysis of the study results in the light of relevant literature both included in the literature review and identified following the data analysis. The discussion will be structured around the objectives that were set at the beginning of the research project. The strengths and limitations of the study will then be discussed followed by the implications that the study findings have for policy, practice and further research.

The challenges facing newly appointed RNs during the first two years of appointment.

The results of the study indicate that there are many challenges facing the new recruit when they first take up post in the Islands. Whilst there are multiple and interconnected factors which contribute to these challenges, the stories of the new recruits demonstrated that they were all experiencing a process of acculturation. It was also recognised that this process of cultural adaptation and change was still being experienced by the longer-serving participants; this drew the conclusion that acculturation is a journey that never ends.

In the previous chapter a flow diagram of the stages the participants went through was depicted in figure five. This model was derived from the interpretation of the selected 16 stories, and was also influenced by the theory reviewed by Muecke et al, (2011) concerning the concept of culture shock. Oberg (1960 cited in Muecke et al, 2011) first introduced the idea that individuals go through a process to manage culture shock, his model suggests that the process is a linear one beginning with a positive honeymoon phase and ending with a positive effective functioning stage. However the interpretation of the 16 stories indicated that participants may fluctuate between stages depending on their own characteristics as well as the contextual factors impacting on them at the time. There were also examples where participants did not go through a honeymoon stage and skipped to the rejection or resolution stage on taking up employment. In addition to this, a pre-employment phase was added to the model in recognition of the participants' past experiences, their reasons for wishing to work in

the islands, their expectations of what their 'life' will be like when they move to the islands, their existing self-care and coping strategies and their language proficiency. It was recognised through the interpretation of these stories that these factors impacted on their ability to cope and adapt to the reality of Island living and the perception of the challenges they faced. These factors, which are intrinsic in nature, are highlighted in the literature reviewed (Hayne et al, 2009, Le and Kirkpatrick 2008, Newton et al, 2012; Sochan and Singh 2007; Beechinor and Fitzpatrick 2008; Muecke et al, 2011; Al-Omari and Pallikkathayil 2008; Ea et al, 2010).

The acculturation process was also influenced by a number of external, contextual challenges which were identified in the themes arising from the analysis of the data set as a whole. One set of key challenges related to the Island context both in terms of its infrastructure and the experience of living on an island. The issues raised by the new recruits were closely aligned with those identified in the literature, especially in relation to housing, the cost of travel, lack of amenities and lack of anonymity (Williams et al, 2007; Veitch et al, 2012; Yates et al, 2012; Battye and Mc Taggart 2003; Keane et al, 2012). However, it is argued that the nature of these issues is context specific. For example housing in the islands is a challenge, not only due to availability and cost as experienced in other remote and rural areas, but also due to the local legislative restrictions which have been imposed to control population growth. The housing laws associated with the islands, impact on the choice of accommodation available to new recruits; some are restricted to renting 'government owned' property only. The results section highlighted accommodation as being a major issue of concern for local new recruits, with some expressing high levels of dissatisfaction with this aspect of 'island-life'.

Another key challenge for the new recruits was associated with the organisational context and the provision of health and social services on the Islands. Most of the new recruits had been employed in larger organisations in the NHS prior to taking up post in Alderney or Guernsey. In addition to making an adjustment to Island life, the new recruits had to make varying degrees of adjustment to the way in which health and social care is delivered in the Islands. New recruits join the organisation with preconceived values, beliefs, practices and attitudes acquired from working in previous organisational cultures. It is recognised that these may not necessarily fit with

the organisational culture they are now working in. This incongruence acts as a catalyst for the acculturation process to take place, beginning with the discomfort of culture shock (Hewege 2011; Muecke et al, 2011).

As indicated in the results section, the new recruits were very much aware of their professional accountability and were concerned that practice in the Islands did not always conform to national standards and guidelines. The participants who had been working in the UK NHS had been accustomed to working in a culture of managerialism, where practice is scrutinised and governed through specific organisational processes (Traynor, 2013). The promotion of a safety culture within the NHS has been high on the agenda and arguably has resulted in the over reliance on guidelines and standards to direct practice with the intention of avoiding mistakes. On taking up post the new recruits found themselves immersed in a culture where the medical staff were very powerful and had a high level of autonomy; the immature governance infrastructure did little to curtail this power. In addition the lack of support from the local legislation which is not always aligned with the UK, added to the anxieties experienced by these participants. The shock of moving from a culture which is risk averse to one that allows deviation from standards and protocols was evident in their narratives

The new recruits were particularly challenged by the lack of available expertise in the form of resident junior doctors. This had considerable impact on the scope of their professional role resulting in the RNs making more clinical decisions, which would normally be undertaken by the medical staff. The literature indicates that this is not uncommon in remote and rural settings (Drury et al, 2005), however it also highlights that the regulatory bodies do not recognise practice which extends beyond the scope of the nursing role (Vukic and Keddy, 2002). This is certainly true for the practice of accepting verbal orders for medication and resuscitation status by the RNs who work in the Islands. The new recruits were evidently shocked by this practice but admitted to having accepted an order. Amalberti et al, (2006) have produced a framework which provides insight into how this 'deviant' practice has become an organisational norm. Firstly the acceptance of verbal orders needed to be perceived as a benefit more than a risk, the excerpts from the narratives indicate this was the case. Secondly, medical staff benefitted in that they could order treatment over the telephone without leaving home. Thirdly management were supportive of the practice, as demonstrated by the

excerpt which described how the nurse in charge at night took a verbal order to obtain a do not resuscitate order. Fourthly there were clear 'rules' in the medicines policy at the time as to how orders were taken and recorded; adding to the perception that this practice was safe. These four conditions together with the fact that this practice has continued for many years, indicates that the organisation had reached the normalization of deviance stage of Amalberti et al,'s model; the acceptance of verbal orders had become part of normal practice in the Islands. This practice has now ceased as a result of an exceptional review of maternity services (NMC, 2014) in Guernsey. However the concerns raised by the new recruits in this study indicate the value they could bring in the early stages of their employment in highlighting potential poor practice which has become the norm.

The results of the study indicate that the new recruits were challenged by the breadth of the role on taking up post, especially if employed in Alderney. The requirement to take on certain managerial and administrative functions in addition to their nursing duties added to this challenge. Conversely some of these new recruits were concerned about the lack of opportunity to use certain specialist skills and felt they were in danger of losing them if they remained in post. This issue associated with achieving and maintaining competence in a wide range of skills when working in small community settings is well documented in the literature (Drury et al, 2005; Helbok, 2003; Keane et al, 2012; Malone 2012; Mills et al, 2011; Weiss Roberts et al, 1999). However, the opportunity to develop a broad range of skills was considered to be a positive challenge which promoted learning and development. This was perceived as a positive attraction for recruitment, both by the participants in the study and the literature reviewed (Leipert and Anderson, 2012; Nayda and Cheri, 2008).

The challenges faced by new recruits were varied but were not any different to those experienced in other small, remote and rural communities. Whilst the findings were unsurprising it is apparent that the individual's response to these challenges will depend on their own characteristics including their ability to cope, adapt and change. In addition the precise issues associated with the challenges may differ slightly from one context to another and as a consequence may require different approaches to address. This supports the perspective that small, remote and rural communities

require more context specific enquiry due to their unpredictable and complex nature (Nayda and Cheri 2008; Yates et al, 2012).

Establish the scope of the occupational role of the generalist expert nurse employed in two small island communities and explicate the challenges they continue to face in their role.

The 15 expert nurses included in the study were from a wide variety of backgrounds and had been employed in the islands for over 5 years, with some being in post for much longer. They had seen the health and social care services diversify and grow in response to the increased specialisation of healthcare at a national and global level. This study did not achieve the objective of establishing the scope of the generalist role as this would require a different line of enquiry, using an alternative methodology. However the data obtained from this group of participants gave insight into the challenges they faced in providing services which in themselves were demanding a wide scope of practice; some of these will be discussed in more detail.

It is suggested that staff who have been recruited from larger urban settings can experience a feeling of moving from expert to novice when they take up post in a small, remote and rural setting (Rosenthal, 2005). Although the new recruits did not specifically make this statement, the longer-serving RNs indicated that new employees rarely had the full skill set required for the role they were employed into. This was especially true for those employed to work on the paediatric unit, the acute mental health unit, the critical care unit and Alderney; the scope of practice is very broad in these areas. Closing the skill-gap in the new recruit required investment from the long-serving staff to 'bring them up to standard'.

The staff turnover and use of agency staff contributes to this additional workload, in that skilled staff are replaced by new staff with a skill deficit. The management of this staff turnover is not only expensive (Humphreys et al, 2009) but is also costly in terms of the investment required to ensure the new recruit has the necessary competence for their role in Guernsey or Alderney. The extent of this investment is difficult to determine, although it is evident that time and money are involved. The results of the study indicate that the staff working in an environment of high staff turnover and

agency use, were exhibiting certain negative emotions which they may be forced to suppress in the workplace, adding further to their 'burden'. The potential 'emotional labour' (Hochschild, 2003) involved in being a long-serving member of a small team of constant changing membership could be a focus of further study.

The longer serving participants were also challenged by the expectation to provide care and services in line with national standards and guidelines. There was a feeling amongst these individuals that the standards did not always fit with the context of care on the islands and the resources available to meet those standards. This perspective is supported by the literature (Paliadelis et al, 2012; Veitch et al, 2012; Wolstencroft and Macvicar, 2011) and also by bodies such as the Scottish Intercollegiate Guideline Network (SIGN) who produce guidelines which acknowledge the differences in the remote and rural context. Despite the fact that staff working on both islands recognised the problem of meeting national standards, one of the longer-serving participants felt that 'Guernsey' tended to make a judgement on the care provided by staff in Alderney based on the resources available in Guernsey.

This led to a line of critical thought which proposed that the decisions regarding the adequacy of care provided sits with the individual who is the most specialised in that field. Friedson (2001) suggests that someone can be assumed to be a specialist only when they are compared to someone else. As a consequence the front line generalist staff in Alderney who are expected to be a 'jack of all trades' are judged 'to not be good enough' by the emergency team in Guernsey who have emergency care doctors and nurses in the department with access to a team of specialist consultants. In turn the care provision in Guernsey is judged by regulatory review teams who have an expectation that care provision will conform to national standards despite the size of the organisation and the population it serves. It is further hypothesised that specialist centres in the UK would impose an expectation on the care provided by a district general hospital, based on the high level of expertise they have available in the specialist centre. This perspective is underpinned by the notion that specialisation brings with it the status, power and prestige, placing it in a superior position to that of the less specialised (Friedson, 2001). The specialisation of services and their perceived superiority have influenced public expectation. One of the longer-serving participants stated that the Guernsey community expected that specialist services

would be available on the Island despite the limitations of the resources available. Managing these expectations was challenging especially in the light of published standards and the increasing political will to reduce the cost of care provision on the islands.

Paradoxically, whilst the longer-serving participants called for a more realistic perspective on the range of specialist services which should be available on the Islands, there was an acceptance that specialist expertise had its place in the provision of care. The RNs in Guernsey were dependent on the skills and knowledge of the specialist nurse when faced with situations which were complex and uncommon. The RNs in Alderney appeared to be more dependent on specialist input from Guernsey and were relieved that technology had enabled this to be more accessible. The division of labour and specialisation of knowledge and skill creates an interdependency between the team members. Whilst this can result in a positive outcome for the patient, the dependency on others for specialist input is problematic in a context where there is only one person in that role. One of the criticisms of specialist roles is that they can erode the knowledge base and skill set of the generalist within that particular field of practice (Gardiner et al, 2012; Jack et al, 2004). If there is just one nurse occupying a specialist role then there is a risk that a knowledge and skill gap will exist when they are not available. However, the literature does support a blended approach to the provision of services, where both generalist and specialist roles have their place; the generalist being the constant co-ordinator of care and the specialist providing the specific input into a component of the client's care (Ahmed et al, 2003; Beulieu et al, 2008; Crossley and Lepping 2009; Harris and Harris 2006; Freed et al, 2009; Gardiner et al, 2012; Gott et al, 2011; Manca et al, 2011; Stille et al, 2005).

In 2011 McClean identified that HSSD as an organisation was experiencing a critical conjuncture as a result of the financial transformation programme which demanded service managers to make efficiency savings, including cuts to services. A critical conjuncture (Oliver and Mossialos, 2005) provides a window of opportunity to change the direction of a policy path. McClean (2011) suggested that this was a good time for the organisation to fully embrace clinical governance within organisational policy to assure the quality of care provision at a time when financial cutbacks threatened services. It was apparent from the narratives provided by the longer serving

participants obtained two years later that they were having to adapt to the cultural shift from one where money and resources were plentiful, to a situation where the economy of the Island was in a deficit. It is argued here that some if not all of the longer-serving participants were going through some process of acculturation as a response to the changing climate they found themselves working in. The results section demonstrate that some of the staff were in the conflict stage of the acculturation process, others demonstrate some resolution to the cultural changes that needed to be made (Oberg, 1960 cited in Muecke et al, 2011).

Furthermore, the results section highlighted the perspectives of two of the participants on the reporting of incidents at the time of the study. They both expressed negative perceptions of this process indicating the existence of a blame culture within the organisation rather than one of openness, and learning. These perceptions together with the NMC review of maternity services in 2014, indicated that little progress had been made in developing a clinical governance policy that had impact on the organisational culture. The existence of illegal and unsafe practice, such as the use of verbal orders, added further to the perception that governance processes were poorly developed at the time of the research.

Scally and Donaldson (1998) and other authors (McSherry and Pearce 2002; Currie et al, 2003; Ritchie et al, 2005) identified by McClean (2011), indicate that effective governance was dependent on an organisation that is committed to quality improvement, patient safety, and the management of risk. In addition the organisational culture should be open, developmental and use blame 'exceptionally'. It was clear from the narratives that culturally the organisation required further change to embrace the key tenets required for effective governance to permeate through the organisation. The NMC review and on-going monitoring of an action plan for implementing more robust governance structures has created a critical conjuncture which is forcing change. The staff will be expected to acculturate to a new way of working, where patient safety is paramount. It should be recognised that staff will respond in different ways as they adapt and change to a new culture, some may enter a conflict stage and never return to the resolution stage; this could result in some people choosing to leave the organisation. Although it could be argued that the requirement to make cultural adjustments is not unique to the staff working on the

Islands, the resources needed to develop and implement the varying procedures and processes involved with 'good governance' may be the challenge. CRANA plus (2013) recognised this challenge in their guide to developing clinical governance in remote and rural areas in Australia. They went on to point out how each rural and remote context was unique and the way in which they developed their infrastructure will depend on the size, structure and resources available. This perspective needs to be kept in mind when developing the local governance framework, to ensure that the systems in place are sustainable and not just a carbon copy of those in place in bigger organisations.

Finally, another major challenge facing the longer- serving participants were the ethical dimensions associated with their lack of anonymity and the close proximity of their client group outside of the work setting. These dilemmas were also highlighted in the literature reviewed (Weiss Roberts et al, 1999; Helbok 2003; lee and Winters 2004; Malone 2012; Paliadelis et al, 2012). One common issue experienced by the longer serving participants and to a certain extent the new recruits, is a lack of anonymity outside of the work setting, especially those based in Alderney. Participants would often come across their patients and clients within the community setting. At times this encounter felt intrusive especially if the staff member was in a position of compromise such as being on the beach in their swimwear. Some clients would start to engage in a conversation about their particular healthcare situation or that of their relative. The management of role boundaries is a common problem for professionals working in small communities, especially when they become more integrated into the community and undertake multiple roles, which can lead to role ambiguity and role conflict (Weiss Roberts et al, 1999; Rosenthal 2005). The participants in this study highlighted how clients were not very 'boundaried' and felt able to 'launch into a big tirade about their child in the middle of the high street'. This is supported by a study by Iverson et al, (2002) who found that this visibility made it difficult for rural GPs to 'escape their professional role'.

The visibility of the professional in the community and the pressure to maintain their professional reputation was also an issue. One of the new recruits recognised this early on in their employment and felt as though they were being observed when they were off duty. This dilemma was also highlighted by Helbok (2003) who suggested

that service users often knew a great deal about the healthcare professional before they even met them. At the same time the healthcare professionals are often party to a deal of information about the community members before they become service users. This appeared to be more of an issue for the new recruits, especially those in Alderney. However it could be argued that the new recruits provided a useful prompt for the longer-serving recruits to critically reflect on their preconceived perceptions of the service users, which may be impacting on how they care for certain individuals within the community. Mezirow et al, (2000) provides a framework to facilitate transformative learning which involves challenging the assumptions the individual holds and uses to guide their behaviours.

Another major challenge facing the longer-serving participants was maintaining confidentiality in a context where everyone knows each other. This was a particular problem in Alderney where the social network is well developed and information is communicated rapidly. Participants from both Islands were able to cite examples of when they were approached by community members requesting information about individuals they were caring for. In addition patients often know each other and will freely exchange information about their health and those of others. Although this behaviour could be perceived as a breach of confidence through 'gossiping', it could also be viewed as a product of the feeling of connectedness between community members (Leipert and Anderson, 2012). The desire to share and receive information could be born out of genuine concern for the well-being of the community member. This connection with the community also extends to the RNs working in the Islands especially if they have made the effort to engage with the social activities available. Although the literature indicates that becoming involved in the community is an important part of not being seen as an outsider (Vukic and Keddy, 2002) and to develop trust between the practitioner and the community member (Mills et al, 2010), it is evident from the narratives that this strong connection can be difficult to deal with when faced with tragic situations involving young members of the community.

There are many on-going challenges facing the longer-serving participants. Other challenges include the lack of anonymity when accessing services, the tensions that can exist when supporting a family member accessing the services and the on-going problem of cost of travel, housing and general living.

Identify strategies to prepare and support RNs to meet the challenges they may face when taking up post in a small island community.

The results of the research provided insight into the potential strategies which could be employed to better prepare and support new RNs when they take up post on the Islands. These strategies will be evaluated in the light of available literature and their potential to improve recruitment and retention of this group of staff on the Islands.

The adapted model of acculturation (Oberg 1960 cited in Muecke et al, 2011) identifies that RNs experience a pre-employment stage which shapes their expectations of their future life in Alderney and Guernsey. It is argued here that HSSD as a future employer has some responsibility in shaping these expectations at this stage of the employment process. Whilst employees will have a contract of employment, it is recognised that they will also develop a psychological contract between themselves and HSSD. This contract is considered to be a 'sophisticated set of expectations and rules which forms the psychological basis for the continuing commitment of an employee to their employer' (Cavanagh 1996, p80). Dadi (2012) argues that the employee will have a set of expectations and personal obligations which are already 'embedded in their mind' when they first take up employment. These are shaped by many factors including the information the employee has available to them about the organisation, the social responsibilities the employee has outside of their work environment, their cultural background and past experiences (Dadi, 2012; Guest 2004).

It is believed by Guest (2004) that the 'state' of the psychological contract created between the employee and employer is directly influenced by the degree to which perceived 'promises' made by the employer are met and whether the contract is seen to have been violated in any way. This has the potential to elicit positive or negative attitudes and behaviours in the employee. Acknowledging that a psychological contract exists between the employee and employer requires HSSD to take some responsibility in negotiating a match between the 'wants' of the employee and what the organisation can offer (Purvis and Cropley, 2003). It is suggested that the 'state' of this contract will have some bearing on the acculturation process experienced by

the employee and will contribute to their decision to remain in employment or to leave (Purvis and Cropley, 2003).

Prior to employment, potential recruits need access to factual information about island life, especially the climate, the cost of living, the choice of accommodation and the pace of Island living. It is evident from the results that there was a mismatch in expectation for some of the participants. Publicity material needs to provide a realistic picture of the climate; the use of blue skies and palm trees can be misleading. Whilst the beaches are sandy and the weather is largely mild, the Islands are not tropical and the summers are just as unpredictable as those in the UK. In addition the cost of living, including the cost of flights was a big surprise for the new recruits. The perception that the islands offer greater tax relief on income and goods and services detracts from the fact that food has to be imported at additional cost and there is a lack of competition in the provision of utilities such as electricity and water.

Potential employees need to be able to make an informed decision as to whether these additional costs are out-weighed by other benefits such as low crime rates. Providing an honest and balanced perspective will go some way to shape the expectations of the employee as well as ensuring that the 'promised' inducements match what is really 'on offer' (Guest, 2004). How this perspective is communicated is a challenge, in that the passive presentation of information alone is unlikely to be effective in managing expectations. Consideration should be given to more interactive forms of communication with potential recruits through the use of social media. For example podcasts of how employees have over-come the challenges of moving to a small community, the coping strategies they have developed and the perceived benefits of island life, will carry more credence with the potential applicant and paint a more balanced view (NHS Employers, 2013). The literature around the use of social media in recruitment is somewhat anecdotal, however the centrality of social media in 21st century living indicates that its potential as a recruitment tool should not be ignored.

One of the main predictors of successful recruitment and retention of staff to remote and rural settings is previous experience of living in that context. The literature indicates that practitioners who have originated from a remote and rural setting or undertook a placement in that setting are more likely to choose a career pathway in a

rural and remote community (Grobler et al, 2009; Jones et al, 2009; RCPE 2005; Strasser et al, 2010; and Wolstencroft and Macvicar 2011). Brooks et al, (2002) believe that the individual feels better prepared to practice in that type of environment if they have had exposure to it as part of their educational experience. Having this type of experience also helps to shape the expectations of the new recruit so that they are more in line with the reality of the situation. Offering opportunities for placement secondments and electives for students and newly qualified staff may be a potential way of recruiting staff to the islands who are more likely to stay in post. At the same time, maintaining contact with local students who have chosen to 'train' off island could provide another pool of applicants with the propensity to remain in HSSD employment.

It is apparent from the results section that many of the new recruits were having some difficulties adjusting to living and working in the Islands and that there is a need for more investment in the support offered to new recruits as suggested in the literature (Al-Ahmadi, 2009; Leurer et al, 2007). On taking up post staff are provided with an induction at a corporate and usually departmental level. Induction is considered to be of benefit in orientating new recruits into the workplace (Nayda and Cher,i 2008; Montour et al, 2008). However the feedback from the participants suggest that attendees perceive it as being a useful conduit to share information related to living on the islands. In respect to the effectiveness of the induction, some participants felt that it needed to be more service specific, especially for those working in Alderney. Further systematic evaluation of corporate and departmental induction is required to ascertain whether these processes are meeting their aims. In addition induction should provide the new recruits with an opportunity to discuss strategies for dealing with the lack of anonymity, role boundaries and maintaining confidentiality within a small community. These issues are not currently addressed in induction despite creating considerable challenge for some of the participants.

The results indicate that employee support is not uniform across the organisation. Staff were offered the opportunity to work in a supernumerary capacity for varying lengths of time at the beginning of their employ but this initiative was dependent on staffing levels and workload. Not all staff have a period of preceptorship despite this being recognised as an accepted means of support for new recruits experiencing the 'reality shock' of taking up post (Kramer, 1974). Whilst this is usually associated with the

socialisation of newly qualified RNs into their first post, it is argued that staff new to the Islands experience their own cultural shock which needs to be managed in a supportive way (Xia, 2009).

The Portuguese and Filipino RNs were provided with an augmented programme of support when they took up post. However these individuals were employed following a recruitment drive in their respective countries of origin and moved to the Island as a group. The Filipino nurses were required to undertake an adaptation programme and the Portuguese nurses were offered additional study days over a three month period. It is difficult to determine how beneficial these enhanced programmes were for these groups of staff, although the collectivist culture of the Filipino nurses would indicate that recruiting them as a group would provide them with a support network in line with their cultural norm (Cheng and Liou 2011; Ea et al, 2007; Hayne et al, 2009; Yi and Jezewski, 2000; Beechinor and Fitzpatrick 2007).

The narratives provided some insight into the struggle some of the participants had in adjusting to life on the islands. One participant cited in the results section described the massive culture shock they experienced, perceiving everything as being 'just pitch black and dark'. Another participant put forward the suggestion that all new employees should be offered additional support including counselling. They went on to propose that it should be considered to be 'natural and normal' to access this help and not be perceived as a weakness. Xia (2009) describes the strategies available to deal with culture shock especially 'during the experience' when 'self-confidence and optimism, accepting the new culture and seeking social support' (p99) are key in dealing with the psychological stress. The organisation has a part to play in recognising the symptoms of culture shock amongst its employees and the potential strategies to deal with it, some of which are considered below.

The individual experiencing culture shock should be encouraged to view it as a temporary phase which is a normal part of adjusting to a new culture (Xia, 2009). In addition good self-care and coping strategies to help individuals deal with the acculturation process should be fostered. These strategies can help preserve the emotional and mental well-being of the individual (Hayne et al, 2009; Le and Kirkpatrick, 2008; Newton et al, 2012; Sochan and Singh, 2007; Beechinor and

Fitzpatrick, 2007). However the analysis of the individual stories demonstrated that new recruits required different forms of support in developing their social capital. Some were pro-active in finding social networks to join or develop, others were keen to invest in the community and in so doing actively contributed to the bank of social capital available to the wider island populace. Conversely it was evident that others would need some guidance to help them to make connections with the wider community, especially those with a more pessimistic outlook, as they are more likely to be anxious and depressed (Xia, 2009). Xia (2009) concludes that the impact of culture shock is influenced as much by personality as it is by the strategies which can be used to deal with it. However they go on to suggest that an understanding of the process of culture shock and developing some knowledge of the new culture before departure is likely to be the most universally effective intervention. This has implications for the material used for recruitment as mentioned previously.

Finally the literature indicates that the acculturation process is also affected by the way the host community receive the new recruit (Hayne et al, 2009; Han and Humphreys 2005; Al-Omari and Pallikkathayil, 2008; Sherman and Eggenberger, 2008). Most participants consider the island community to be 'welcoming and accepting of them'. Unfortunately others had been 'gob-smacked' by the racism which existed in the community. One participant from the Philippines spoke of their disappointment that their recruitment to the Island was 'compared to white slavery' by a high profile member of the community. The island populace has a part to play in supporting new staff from overseas who provide a vital function in the delivery of health services (Han and Humphreys, 2005; Al-Omari and Pallikkathayil et al, 2008). However Guernsey does not have a race discrimination law and is unlikely to have one in the near future (Le Tocq, 2014). HSSD however has a responsibility in generating an organisational culture which is accepting of diversity and difference despite the lack of legislative infrastructure. Having an understanding of the cultural norms of the staff working within the organisation and how this impacts on their expectations of HSSD as an employer will go some way to avoid potential violations of the psychological contract between the two parties involved (Guest, 2004).

Contribute to the identification of the professional development needs and support required for generalist RNs to achieve expertise in their professional roles within a small community

The study did not achieve the objective of establishing the scope of practice of the expert generalists, however it has been possible to make some recommendations around the developmental needs of generalist RNs working in small communities. Referring back to the adapted model of the acculturation process, it is argued that an expert practitioner who is effectively practicing in their role would be situated in the fully functioning stage. This individual would be competent within the scope of their role, fully inculcated within the organisation and integrated with the wider community. However it can also be posited that inculcation within the organisation may not always be a positive outcome if the organisational culture supports poor or illegal practice. Expert generalists need to be culturally competent in that they have a good grasp of the needs of the populace but at the same time can adopt a critical approach to the way the organisation functions.

One of the key challenges facing generalist RNs working in the islands is the broad scope of their practice. Although this can be perceived as a problem, the literature indicates that it is this role breadth which attracts RNs to the role in the first place (Leipert and Anderson, 2012; Nayda and Cheri, 2008). However maintaining competence in a broad knowledge and skill set has already been identified as a problem in this discussion. In addition participants have expressed their concern that they may lose specialist skills due to lack of exposure to situations where they can use them. At the same time, this discussion has identified that there are gaps in service provision, either due to the lack of specialist nurses available at certain times or the absence of resident doctors within the secondary care setting. HSSD to date has not produced a comprehensive workforce plan to identify the roles and competencies needed to deliver a safe and effective service. In turn the provision of education and training has been in response to a 'best guess' approach to the identification of the developmental needs of the workforce. Whilst the availability of education and training has been highlighted as a recruitment tool to remote and rural settings (Grobler et al, 2009; Jones et al, 2009; RCPE, 2005; Strasser et al, 2010; Wolstencroft and Macvicar, 2011; Battye and McTaggart, 2003; Keane et al, 2012; Drury et al, 2005; Mills et al,

2011; Francis and Mills 2010; Leipert and Anderson 2012; Montour 2008; McAuliffe and Barnett 2010; Williams et al, 2007), this needs to be more closely aligned to the provision of services in Alderney and Guernsey, through a more systematic approach to the analysis of training needs.

The HSSD is committed to the development of an organisational workforce plan which is currently being produced. This plan will influence the education and training provision needed to ensure that staff have the requisite competence to support services. New advanced practice roles may emerge as a result of this initiative enabling RNs to legitimately stretch professional boundaries within an agreed governance framework (Nayda and Cheri 2008; Wilson 2007). However this stretching of boundaries need to be negotiated between the professional groups to avoid conflict between the parties concerned (Currie et al, 2009). In addition, individuals undertaking tasks outside of their traditional professional role should consider the impact this might have on the substantive function of the occupational group to which they belong. As stated previously by Abbott (1988) 'no profession can extend its jurisdiction infinitely' (p.88), therefore extending roles into new territory is likely to result in the deskilling of certain tasks and functions.

Skill acquisition and the maintenance of competence is currently achieved through a suite of essential to role and mandatory training initiatives. This training requires a review to ensure it is fit for purpose and covers the range of skills needed to ensure the safe provision of services. The use of simulation has been identified as an effective tool in maintaining competence in skills where the opportunities to practice them are rarely encountered in the clinical setting (Yukie et al, 2013; Bultas et al, 2014; Miller et al, 2014). Although simulation is already being used to maintain staff competence, it is currently underutilised as a potential tool for learning. Further strategic work around the provision of simulation and the potential value of a simulation suite to support this mode of learning is required. The use of off-island placements to 'up-skill' staff working in more specialised environments is also currently supported but could be an option for staff working in more general settings (NHS Scotland, 2007).

The development of competence has been identified as just one aspect of staff development, the other is related to the maintenance of a critical perspective to the

function and culture of the organisation. Off-island placements, networking with counterparts in the UK and critical reflection through supervision may assist the RN in maintaining a 'fresh' perspective on their practice. In addition it is proposed that new recruits should be given the opportunity to share their observations and opinions of the organisation within a year of taking up post. The narratives from this study demonstrate that this group of participants are able to use their 'fresh eyes' to highlight poor practice which may have become the norm.

The continued support of staff during their employ with HSSD is variable. The availability of clinical supervision is very sporadic outside of the mental health setting and is not seen as a priority; managerial support is also inconsistent. The participants indicate that they rely on the informal support of colleagues and peers to discuss any problems or concerns they may have related to their practice. The literature offers some insight into the nature of the support which could be offered to staff to improve recruitment and retention in the remote and rural workforce. Whilst some of these incentives are in place, such as a bonus scheme (Veitch et al, 2012), there are a number of additional supportive mechanisms which could be implemented such as the on-going provision of emotional support and valuing the employee as an individual (Keane et al, 2012; Williams et al, 2007). Consideration needs to be given as to how staff can be supported more formally especially when faced with the organisational challenges and changes they will continue to deal with in the future.

Give 'voice' to the work of the generalist RN employed in small island communities

The last year has placed Guernsey and HSSD under the spot light. The NMC review in 2014 was published nationally and did not portray the maternity services in a positive light. More recently the NMC have returned and provided more favourable publicity of the health services in Guernsey (NMC, 2015b). This is now a good opportunity to consider how the 'voice' of the generalist RN working in small communities can be more readily heard in the development of national standards and policies which have impact on their practice. Students have recently taken part in a NMC listening exercise, to provide their perspective on the standards for pre-registration education programmes. Other similar opportunities need to be grasped to ensure the small

community view point is represented. NHS Scotland (2007) have pro-actively considered the unique requirements of their Highland and Island communities and the challenges facing practitioners working in those environments. Currently HSSD tends to follow NHS England and NICE guidelines, when in fact a better sense of fit may be achieved by aligning with the work of NHS Scotland and SIGN.

Bushy (2000) argues that the theoretical foundations supporting the body of knowledge for remote and rural practice are in their infancy. She contends that the epistemological base is primarily derived from anecdote and descriptions of experience through vignettes. She calls for a more scientific approach to the development of knowledge but recognises that this may be problematic due to the uniqueness of the different contexts associated with rural practice. The transferability and generalisability of study findings may be limited as a result. Despite these concerns, the literature reviewed for this study demonstrated that there is a growing body of research, that remote and rural practice is being recognised as a 'specialism' (Nayda and Cheri 2008; Wilson 2007) and that publications focusing on this area are becoming available including a Journal of Rural and Remote Health.

This study has highlighted some potential areas for future enquiry. It is proposed that this could include other similar Islands with independent jurisdictions such as Jersey and the Isle of Man. Whilst these islands have differences, the fact that they occupy geographically similar locations in respect to the UK mainland, may unite them in terms of the challenges they face in recruiting and retaining staff. These islands have enjoyed relative wealth but are also experiencing the need to constrain public spending whilst maintaining a safe service. Networking with these jurisdictions will provide an opportunity to share experiences as well as provide a stronger collective voice to influence future policy.

Study limitations

This study was undertaken within the context of Alderney and Guernsey, which are two of the Channel Islands. The methodology used considers the data analysis within the context that the study took place. This has the potential to limit the transferability of the findings beyond these two islands. However the sample selected was a

maximum variation purposive sample to capture a broad range of realities as experienced by the participants included in the study (Patton, 1990). In addition, the findings of the study connected with those of other research projects completed elsewhere. This indicates that the themes generated from this particular study have some potential to be transferred to a range of other contexts and staff groups. That said, it was also identified that it is the specific nature of the themes that gave rise to the context dependent challenges experienced by the participants.

Consideration was given to the inclusion of participants who had recently left the Island in order to compare their stories with those who were still employed and living on the Island. It could be argued that since they were no longer in employment they may have exercised greater candour in their responses. This would have required the use of alternative technologies to gather this data. However in view of the fact that 35 participants took part in the research and the transcripts revealed both positive and negative experiences of living and working in the islands indicate that the views presented in this paper would have some credibility with this 'missed' cohort. In addition it should be noted that 13 out of the 20 new recruits have since left the Islands and so now form the group who decided not to stay.

The lead researcher is well known to many of the participants having worked within the organisation for many years. There were concerns that staff agreed to take part in the research by virtue of their relationship with the lead researcher and as such the consent process was compromised. Moreover, it was identified during the transcription of the recordings made of the interviews, that many of the questions posed were leading and value laden. However it was noted that the participants were able to refute the perspective implied in the questioning process, and provide a more accurate account of their reality. Paradoxically this could have been due to the nature of the relationship the participant held with the lead researcher in that they felt able to challenge this individual.

The data collection was commenced three years ago and the final analysis of this data has just been completed now. The data could be out of step with the current situation because of the delay in completing the research process. However it is argued that

the data has been interpreted with reference to the contextual events at the time of collecting the data as well as being considered in the light of more recent events.

CHAPTER SIX

Conclusion

This study was completed over a period of three years and achieved its aim which was 'to explore the professional and personal challenges facing generalist Registered Nurses (RNs) working and living in two small island communities'. Five objectives were set, four of these were completely met and one objective was partially met.

It was recognised that all new recruits undergo a process of acculturation when they take up employment in the Islands. The study demonstrated that the process of acculturation was a continual journey and that the longer-serving participants were also undergoing a process of adjustment to the on-going cultural changes taking place in the organisation. The research highlighted that this acculturation process was influenced by multiple inter-connected factors which contributed to the challenges perceived by the participants. Whilst these factors had some commonality with those identified in the literature, the specific nature of the issues raised by the participants in this study were context dependent.

The results of the study and the discussion which took place in the previous chapter have highlighted a number of recommendations for practice, policy and further research.

1) It should be acknowledged that the acculturation process of new recruits begins before they decide to take up employment on the Islands. The individual will have an expectation of island life and the role they are being employed to fulfil. Recruitment material needs to paint a realistic picture of island life as well as provide enough information about cost of living and the accommodation options to enable the applicant and potential employee to make an informed choice. The use of social media should be explored to facilitate this process.

2) The support available for all employees is currently sporadic and inconsistent. It is recommended that corporate induction is reviewed to ensure it is fit for purpose and that the content addresses the issues related to working in a small community. The departmental inductions should be aligned so that the nature of the support

experienced by the new recruit is consistent regardless of where they are working. Other forms of support such as preceptorship, and clinical supervision for new and longer-serving staff members need to be more explicit in organisational policy and their implementation more closely monitored.

3) The development of a workforce plan for the Islands is needed to ensure that the skill set and roles of the staff are aligned to the needs of the service and the safe and effective delivery of care. Any new roles emerging from this piece of work should be considered in the light of the impact they will have for the core function of the occupational role and any deprofessionalisation of tasks which may ensue.

4) A critical reflective approach should be fostered in all staff to ensure that the function and culture of the organisation is congruent with safe practice. Canvassing the opinion of new recruits within a year of their employment will capture their 'fresh eyes' perspective on 'how things are done' in the Islands. In addition, off-island placements in the UK may contribute to a healthy questioning approach to care delivery and avoid the tolerance of unsafe and illegal practice.

5) The organisation is experiencing a critical conjuncture making it ripe for change in policy direction, particularly in relation to the cultural changes required for effective governance. However it needs to be recognised that this will require cultural adjustment by all staff and as such may result in some people moving to the conflict stage of acculturation. The subsequent emotional and behavioural response associated with this stage will need to be managed. In addition the development of the governance infrastructure should take into account the limitations of the resources available in a small organisation. A direct lift of the systems and processes from a larger organisation in the NHS is unlikely to be sustainable.

6) Globalisation results in the migration of individuals across the world. The recruitment of staff from developing countries such as the Philippines has been publicly criticised and contributed to the notion that the Guernsey community exhibits a certain degree of racism. The political leaders in the islands need to influence the development of legislation and policy commensurate with contemporary frameworks which support a culture of tolerance and equality.

7) HSSD should consider the feasibility of aligning practice more closely with the policies and standards being developed by NHS Scotland and SIGN. The work being undertaken in Scotland is sensitive to the needs of the healthcare organisations based on the Islands and Highlands of Scotland and may have a better sense of fit than the work being undertaken in England.

8) Guernsey and Alderney should begin to network more closely with Jersey and the Isle of Man to provide a more powerful, collective voice for the RNs and other staff working in a small island context. This voice needs to be heard by the policy makers and regulators at a national level to ensure that professional requirements are achievable within the constraints experienced by the registrants working in these settings.

9) This study identified a number of avenues for further enquiry. This included:

- The impact of the emotional labour of supporting new staff joining a small team with a high staff turn over
- Exploration of the scope of the RN role working in the islands with a focus on the core competencies required for the role.

10) The body of knowledge for small, remote and rural practice needs further development. Although the uniqueness of the contexts within this field of enquiry impacts on the transferability and generalisability of research findings, this study has demonstrated that there is some common ground in the issues highlighted and those reported elsewhere. The contribution that this study makes to this body of knowledge is detailed in box one. Research findings such as these reported here need to be shared, locally, nationally and internationally.

Box One: Contribution to the body of knowledge

- 1) Whilst the themes highlighted in the study concur with those identified in the literature, the study demonstrates that these are context dependent and therefore their nature is unique to the Islands of Alderney and Guernsey
- 2) The findings of the study have provided insight into the acculturation process resulting in further development of an existing acculturation model. This involved the inclusion of a pre-employment stage and a suggestion that the movement between the stages within the model is dynamic.
- 3) The study has raised the profile of remote and rural practice and the issues faced by practitioners working within the field of health and social care. It has highlighted the need for these issues to be considered in the development of national guidelines and policy so they 'fit' with the 'small community' context.
- 4) The study highlighted how rapidly staff conformed to poor practice despite their initial concerns around their professional accountability. The value of the 'fresh eyes' of new recruits was recognised as a means to identify where practice may have deviated from the expected norm.

Bibliography

ABBOTT, A. 1988. *The system of professions: An essay on the division of expert labour*, London: The University of Chicago Press.

ADAMS, J. 2000. Use of specialist occupational therapists within residential learning disabilities: a justified case, *British Journal of Learning Disabilities*, 28, pp16-20

AHMED, A., ALLMAN, R., KIEFE, C., PERSON, S., SHANEYFELT, T., SOMS, R., HOWARD, G. & DELONG, J. 2003. Association of consultation between generalists and cardiologists with quality and outcomes of heart failure, *American Heart Journal*, 145(6), pp1086-1093.

AIKEN, L., CLARKE, S., SLOANE, D., SOCHALSKI, J., BUSSE, R., CLARKE, H., GIOVANNETTI, P., HUNT, J., RAFFERTY, A. & SHAMIAN, J. 2001, Nurses' reports on hospital care in five countries, *Health Affairs*, 20(3), pp43-53.

AL-AHMADI, H. 2008. Factors affecting performance of hospital nurses in Riyadh region Saudi Arabia, *International Journal of Healthcare Quality Assurance*, 22(1), pp40-54

ALCOCK, J. & IPHOFEN, R. 2007. Computer-assisted software transcription of qualitative interviews, *Nurse Researcher*, 15(1), pp16-26.

ALEXIS, O. & SHILLINGFORD, A. 2011. Exploring the perceptions and work experiences of internationally recruited neonatal nurses: a qualitative study, *Journal of Clinical Nursing*, 21, pp1435-1442.

ALLEN, D. 2001. *The changing shape of nursing practice: the role of nurses in the hospital division of labour*, London: Routledge.

ALLEN, D. AND HUGHES, D. 2002. *Nursing and the division of labour in healthcare*, London: Palgrave.

AL-OMARI, H. & PALLIKATHAYIL, L. 2008. Psychological acculturation: a concept analysis with implications for nursing practice, *Journal of Transcultural Nursing*, 19(2), pp126-133.

AMALBERTI, R. VINCENT, C., AUROY, Y. & DE SAINT MAURICE, G. 2006. Violations and migrations in healthcare: a framework for understanding and management, *Quality Safe Healthcare*, 15(supp1), ppi66-i71.

ARANDA, S. AND STREET, A. 2000. From individual to group: use of narratives in a participatory research process, *Journal of Advanced Nursing*, 33(6), pp791-797

AYANIAN, J., HAUPTMAN, P., GUADAGNOLI, E., ANTMAN, E., PASHOS, C. & MCNEIL, B. 1994. Knowledge and practices of generalist and specialist physicians regarding drug therapy for acute myocardial infarction, *The New England Journal of Medicine*, 331(17), pp113-142.

BAKER, E., SCMITZ, D., WASDEN, S., MACKENZIE, L. & EPPERLY, T. 2012. Assessing community health center (CHC) assets and capabilities for recruiting physicians: the CHC community Apgar questionnaire, *Rural and Remote Health*, 12(2179), available from <http://www.rrh.org.au> last accessed 05/02/2016.

BAKER, T & WANG, C. 2006. Photovoice: use of a participatory action research method to explore the chronic pain experience in older adults, *Qualitative Health Research*, 16(10), pp1405-1413.

BARCLAY, S., TODD, C., GRANDE, G. & LIPSCOMBE, J. 2002. Controlling cancer pain in primary care: the prescribing habits and knowledge base of general practitioners, *Journal of Pain and Symptom Management*, 23(5), pp383-392.

BARREIRA, P., TEPPER, M., GOLD, P., HOLLEY, D. & MACIAS, C. 2010. Adapting evidence-based interventions to fit usual practice: staff roles and consumer choice in psychiatric rehabilitation, *Psychiatry Q* 81, pp 139-155

BATTYE, K. & MCTAGGART, K. 2003. Development of a model for sustainable delivery of outreach allied health services to remote north-west Queensland, Australia, *Rural and Remote Health*, available from <http://rrh.deakin.edu.au/> last accessed 05/02/2016.

BEATON, M. & WALSH, J. 2010. Overseas recruitment: experiences of nurses immigrating to Newfoundland and Labrador, 1949-2004, *Nursing Inquiry*, 17(2), pp173-183.

BEAULIEU, M., RIOUX, M., SAMSON, L. & BOUCHER, L. 2008. Family practice: professional identity in transition. A case study of family medicine in Canada, *Social Science & Medicine*, 67, pp1153-1163

BEECHINOR, L. & FITZPATRICK, J. 2008. Demands of immigration among nurses from Canada and the Philippines, *International Journal of Nursing Practice*, 14, pp178-187.

BENNER, P. 2001. *From novice to expert: excellence and power in clinical nursing practice*, a commemorative edition, New Jersey: Prentice-hall health

BERGIN, M. 2011. NVivo 8 and consistency in data analysis: reflecting on the use of a qualitative data analysis programme, *Nurse Researcher*, 18(3), pp6-12.

BERNETH, M., DIETSCH, E. & DAVIS, C. 2012, Forced into exile: the traumatising impact of rural aged care service inaccessibility, *Rural and Remote Health*, 12, available from <http://www.rrh.org.au> last accessed 14/02/2016.

BIGBEE, J. 2007. The relationship between nurse to population ratio and population density: a pilot study in a rural/frontier state, *Online Journal of Rural Nursing and Healthcare*, 7(2), pp36-43.

BIRDEN, H. & WILSON, I. 2012. Rural placements are effective for teaching medicine in Australia: evaluation of a cohort of students studying in rural placements,

Rural and Remote Health, 12(2167), available from <http://www.rrh.org.au> last accessed 05/02/2016.

BLAXTER, I., HUGHES, C. & TIGHT, M. 2001. *How to research*, 2nd edition, Buckingham: Open University Press

BLOM, B. 2004. Specialisation in social work practice, *Journal of Social Work*, 4(1), pp25-46.

BLUMENREICH, M. 2004. Avoiding the pitfalls of 'conventional' narrative research: using poststructural theory to guide the creation of narratives of children with HIV, *Qualitative Research*, 4(1), pp77-90.

BOGGIS, A. & CORNFORD, C. 2007. General practitioners with special interests: A qualitative study of the views of doctors, health managers and patients, *Health Policy*, 80, pp172-178.

BOLD, C. 2012. *Using Narrative in Research* London: Sage

BOWLING, A. 2009. *Research methods in health: investigating health and health services*, 3rd edition, England: Open University Press

BREVETTI, G., OLIVA, G., GIUGLIANO, G., SCHIANO, V., DE MAIO, J. & CIARIELLO, M. 2007. Mortality in peripheral arterial disease: A comparison of patients managed by vascular specialists and general practitioners, *JGIM*, 22, pp639-644.

BROOKS, R., MARDON, R. & CLAWSON, A. 2003. The rural physician workforce in florida: a survey of US- and foreign – born primary care physicians, *The Journal of Rural Health*, 19:4, pp484-491.

BROOKS, R., WALSH, M., MARDON, R., LEWIS, M. & CLAWSON, A. 2002. The roles of nature and nurture in the recruitment and retention of primary care physicians in rural areas: a review of the literature, *Academic Medicine*, 77, pp790-798.

BROOKES, K., DAVIDSON, P., DALY, J. & HANCOCK, K. 2004. Community health nursing in Australia: a critical literature review and implications for professional development, *Contemporary Nurse*, 16, pp195-207

BROWN, D. & JAMES, G. 2000. Physiological stress response in Filipino-American immigrant nurses: the effects of residence time, life-style and job strain, *Psychosomatic Medicine*, 62, pp394-400

BRYMAN, A. 2008. *Social research methods*, 3rd ed., Oxford: Oxford University Press

BUCHAN, J. 2008. *How can the migration of health service professionals be managed so as to reduce any negative effects on supply?* Denmark: WHO

BULTAS, M., HASSLER, M., ERCOLE, P. & REA, G. 2014. Effectiveness of high-fidelity simulation for paediatric staff nurse education, *Paediatric Nursing*, 40(1), pp27-42.

BURNARD, P., GILL, P., STEWART, K., TREASURE, E. & CHADWICK, B. 2008. Analysing and presenting qualitative data, *British Dental Journal*, 204(8), pp429-432.

BURT, J., SHIPMAN, C., ADDINGTON-HALL, J. & WHITE, P. 2008. Nursing the dying within a generalist caseload: A focus group of district nurses, *International Journal of Nursing Studies*, 45, pp1470-1478.

BUSHY, A. 2000. *Orientation to nursing in the rural community*, California: Sage

BUSHY, A. 2006. Nursing in rural and frontier areas: issues, challenges and opportunities, *Harvard Policy Review*, 7(1), pp17-27.

CAMPBELL, N., MCALLISTER, L. & ELEY, D. 2012. The influence of motivation in recruitment and retention of rural and remote allied health professionals: a literature review. *Rural and Remote Health*, 12(1900) available from <http://www.rrh.org.au> last accessed 05/02/2016.

CARD, S., SNELL, L. & O'BRIEN, B. 2006. Are Canadian general internal medicine training program graduates well prepared for their future careers? *BMC Medical Education* available from <http://www.biomedcentral.com/1472-6920/6/56> last accessed 05/02/2016

CARLSEN, B., & BRINGEDAL, B. 2011. Attitudes to clinical guidelines – do GPs differ from other medical doctors? *BMJ Quality Safety*, 20, pp158-162.

CAROLAN, M. 2003. Reflexivity: a personal journey during data collection, *Nurse Researcher*, 10(3), pp7-14.

CARR, S., LHUSSIER, M. & WILCOCKSON, J. 2005. Buying in specialist time or buying out generalist time for practice development, *Practice Development in Healthcare*, 4(4), pp171-179.

CAVANAGH, S. 1996. A new psychological contract for nurses: some management implications, *Journal of Nursing Management*, 4(2), pp79-83.

CENTRE FOR EVIDENCE BASED MEDICINE (CEBM) 2009/ 2014. *Asking focussed questions* available from <http://www.cebm.net/asking-focused-questions/> accessed in 2009, more recently 04/02/2016.

CHENG, C. & LIOU, S. 2011. Intention to leave of Asian nurses in US hospitals: does cultural orientation matter? *Journal of Clinical Nursing*, 20, pp2033-2042.

CHRISTIANS, C. 2000. *Ethics and politics in qualitative research* in DENZIN, N. & LINCOLN, S. (eds) *Handbook of Qualitative Research* (pp133-155) London: Sage.

CLANCY, M. 2013. Is reflexivity the key to minimising problems of interpretation in phenomenological research? *Nurse Researcher*, 20(6), pp12-16.

CLARKE, K. 2009. Uses of a research diary: learning reflectively, developing understanding and establishing transparency, *Nurse Researcher*, 17(1), pp68-76.

CLARK, C., PARKER, E. & GOULD, T. 2005. Rural generalist nurses' perceptions of the effectiveness of their therapeutic interventions for patients with mental illness, *Australian Journal of Rural Health*, 13, pp205-213.

CRANA PLUS. 2013. *A clinical governance guide for remote and isolated health services in Australia*, Australia: CRANA plus.

CROSSLEY, D. & LEPPING, P. 2009. Role confusion, values-based practice and the demise of the generalist, *The Psychiatrist*, 33, p7-9.

CURRIE, L., MORRELL, C. AND SCRIVENER, R. 2003. *Clinical governance: an RCN resource guide*, London:RCN

CURRIE, G., FINN, R. & MARTIN, G. 2009. Professional competition and modernizing the clinical workforce in the NHS, *Work Employment and Society*, 23(2), pp267-284

DADI, V. 2012. Promises, expectations and obligations – which terms best constitute the psychological contract? *International Journal of Business and Social Science*, 3(19), pp88-100.

DEHAENE, I., GRIETENS, H. & VERSCHUEREN, K. 2010. Holding harm: narrative methods in mental health research on refugee trauma, *Qualitative Health Research*, 20(12), pp1664-1676.

DEPARTMENT OF HEALTH. 2004. *The configuring hospitals evidence file, parts one and two*, London: DoH

DEWITT, D., CURTIS, R. & BURKE, W. 1998. What influences career choices among graduates of a primary care training programme? *Journal of General Intern Medicine*, 13, pp257-261

DICICCO-BLOOM, B. & CRABTREE, B. 2006. The qualitative research interview, *Medical Education*, 40, pp314-321.

DONNELLEY, R. 2008. *Delivering for remote and rural healthcare: the final report of the remote and rural workstream*, Edinburgh: Scottish Government

DORR, D., WILCOX, A., DONNELLY, S., BURNS, L. & CLAYTON, P. 2005. Impact of generalist care managers on patients with diabetes, *Health Research and Educational Trust* 40:5, pp1400-1421.

DOWLING, M. 2004. Hermeneutics: an exploration, *Nurse Researcher*, 11(4), pp30-39.

DRAPER, A. AND SWIFT, J. 2011. Qualitative research in nutrition and dietetics: data collection issues, *Journal of Human Nutrition and Dietetics*, 24, pp3-12.

DRURY, V., FRANCIS, K. & DULHUNTY, G. 2005. The lived experience of rural mental health nurses, *Online Journal of Rural Nursing and Healthcare*, 5:1, pp19-27.

DURKHEIM, E. [1893]1984. *The division of labour in society*, New York:Palgrave.

DURY, C., HALL, C., DANAN, J-L., MONDOUX, J., BARBIERI-FIGUEIREDO, M., COSTA, M. & DEBOUT, C. 2014. Specialist nurse in Europe: education, regulation and role, *International nursing review*, 61, pp454-462.

EA, E., GRIFFIN, M., LEPLATTENIER, N. & FITZPATRICK, J. 2008. Job satisfaction and acculturation among Filipino registered nurses, *Journal of Nursing Scholarship*, 40(1), pp46-51.

EA, E., ITZHAKI, M., EHRENFELD, M. & FITZPATRICK, J. 2010. Acculturation among immigrant nurses in Israel and the United States of America, *International Nursing Review*, 57, pp443-448

ENGSTROM, S., FOLDEVI, M. & BORGQUIST, L. 2001. Is general practice effective? A systematic literature review, *Scandinavian Journal of Primary Healthcare*, 19, pp131-144.

EUROPEAN OBSERVATORY ON HEALTH SYSTEMS POLICIES. 2006. *The healthcare workforce in Europe: learning from experience*, Europe: EOHSP

FENDRICK, A., HIRTH, R. & CHERNEW, M. 1996. Differences between generalist and specialist physicians regarding helicobacter pylori and peptic ulcer disease, *The American Journal of Gastroenterology*, 91:8, pp1544-1548

FERNANDEZ, R. & GRIFFITHS, R. 2007. Portable MP3 players: innovative devices for recording qualitative interviews, *Nurse Researcher*, 15(1), pp7-15

FINK, A. 2005. *Conducting literature reviews: From the internet to paper*, London: Sage

FONTANA, A. & FREY, J. H. 2000. *The interview: From structured questions to negotiated text*. In N. K. DENZIN, & Y. S. LINCOLN (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 645-672). Thousand Oaks, CA: Sage.

FRANCIS, K. & MILLS, J. 2011. Sustaining and growing the rural nursing and midwifery workforce: Understanding the issues and isolating directions for the future, *Collegian*, 18, pp55-60.

FRASER, H. 2004. Doing narrative research: analysing personal stories line by line, *Qualitative Social Work*, 3(2), pp179-201

FREED, G., DUNHAM, K., SWITALSKI, K., JONES, M. & MCGUINNESS, A. 2009. Recently trained general pediatricians: perspectives on residency training and scope of practice, *Pediatrics*, 123, pps38-43

FRIEDSON, E. 2001. *Professionalism*, Cambridge: Polity

GADAMER, G. 1989 *Truth and Method*, 2nd edition, London: Sheed and Ward cited in DOWLING, M. 2004. Hermeneutics: an exploration, *Nurse Researcher*, 11(4), pp30-39.

GARDINER, C, GOTT, M. & INGLETON, C. 2012. Factors supporting good partnership working between generalist and specialist palliative care services: a systematic review, *British Journal of General Practice*, May, pp353-362

GEANELLOS, R. 2000. Exploring Ricoeur's hermeneutic theory of interpretation as a method of analysing research texts, *Nursing Inquiry* 7, pp112-119.

GODDEN, D., LUDBROOK, A., MCINTYRE, L., PEREZ, J. & HARVEY, R. 2004. Consultant supported intermediate care – a model for remote and island hospitals, *Rural and Remote health*, 276 available from www.rrh.org.au accessed 2/4/10

GOTT, M., SEYMOUR, J., INGLETON, C., GARDINER, C. & BELLAMY, G. 2011. That's part of everybody's job: the perspectives of healthcare staff in England and New Zealand on the meaning and remit of palliative care, *Palliative Medicine*, 26(3), pp232-241.

GRAY, C., HOGG, R. & KENNEDY, C. 2011. Professional boundary work in the face of change to generalist working in community nursing in Scotland, *Journal of Advanced Nursing*, 67(8), pp1695-1704

GREADY, P. 2008. *The public life of narratives: Ethics, politics, methods*. In ANDREWS, M., SQUIRE, C. & TAMBOKOU, M. (Eds.), *Doing narrative research* (pp.137-150). London: Sage.

GREENHALGH, T., RUSSELL, T. & SWINGLEHURST, D. 2005. Narrative methods in quality improvement research, *Quality Safe Healthcare*, 14, pp443-449.

GREENHALGH, T. AND WENGRAL, T. 2008. Collecting stories: is it research? Is it good research? Preliminary guidance based on the Delphi technique, *Medical Education*, 42, pp242-247.

GROBLER, L., MARAIS, S., MABUNDA, S., MARINDI, P., REUTER, H. & VOLMINK, J. 2009. *Interventions for increasing the proportion of health professionals practising in rural and other underserved areas (review)*, The Cochrane Collaboration: Wiley

GUERNSEY TOMORROW. 2007. *Part 2: resources (opportunities and constraints)*, available from www.guernseytomorrow.gg/ accessed 26/06/10

GUEST, D. 2004. Flexible employment contracts, the psychological contract and employee outcomes: an analysis and review of the evidence, *International Journal of Management Reviews*, 5/6(1), pp1-19.

H&I LABOUR. 2011. *18 fewer nursing and midwifery posts in NHS Shetland by next March since the SNP Government took power*, available from <http://www.handilabour.org.uk/shetlandlabour/index.htm> accessed 03/01/2012

HABERMAS J. 1990. *Moral Consciousness and Communicative Action*, Cambridge: Polity Press cited in DOWLING, M. 2004. Hermeneutics: an exploration, *Nurse Researcher*, 11(4), pp30-39.

HAN, G. & HUMPHREYS, J. 2005. Overseas-trained doctors in Australia: community integration and their intention to stay in a rural community, *Australian Journal of Rural Health*, 13, pp236-241.

HANSEN, H. 2006. The ethnonarrative approach, *Human relations*, 59(8), pp1047-1075.

HANSSON, A., FRIBERG, F., SEGESTEN, K., GEDDA, B. & MATTSSON, B. 2008. Two sides of the coin – general practitioners' experience of working in multidisciplinary teams, *Journal of Interprofessional care*, 22(1), pp5-16.

HARRIS, M. & HARRIS, E. 2006. Facing the challenges: general practice in 2020, *MJA*, 185(2), pp122-124.

HAYNE, A., GERHARDT, C. & DAVIS, J. 2009. Filipino nurses in the United States: recruitment retention, occupational stress and job satisfaction, *Journal of Transcultural Nursing*, 20(313), pp313-322.

HEALTH AND SOCIAL SERVICES DEPARTMENT. 2010. *Staffing levels*, Guernsey: HSSD.

HEALTH AND SOCIAL SERVICES DEPARTMENT. 2011. *2020 vision: a strategic framework*, Guernsey: HSSD.

HEALTH AND SOCIAL SERVICES DEPARTMENT. 2013 *Labour turnover*, Guernsey: HSSD.

HEALTH AND SOCIAL SERVICES DEPARTMENT. 2016. *Staffing vacancies and labour turnover*, Guernsey: HSSD.

HELBOK, C. 2003. The practice of psychology in rural communities: potential ethical dilemmas, *Ethics and Behaviour*, 13(4), pp367-384

HERACLEOUS, L. & BARRETT, M. 2001. Organizational change as discourse: communicative actions and deep structures in the context of information technology implementation, *Academy of Management Journal*, 44(4), pp755-778.

HEWEGE, C. 2011. Acculturation and management control – Japanese soul in Sri Lankan physique, *Contemporary Management Research*, 7(1), pp3-20.

HIRTH, R., FENDICK, M. & CHERNEW, M. 1996. Specialist and generalist physicians' adoption of antibiotic therapy to eradicate helicobacter pylori infection, *Medical Care*, 12, pp1199-1204.

- HOANG, H., LE, Q. & KILPATRICK, 2012. Small rural maternity units without caesarean delivery capabilities: is it safe and sustainable in the eyes of health professionals in Tasmania? *Rural and Remote Health*, 12, available from <http://www.rrh.org.au> last accessed 14/02/2016.
- HOCHSCHILD, A. 2003. *The Managed Heart: Commercialization of Human Feeling* 20th anniversary edition, Berkeley: University of California Press.
- HOFSTEDE, G., HOFSTEDE, G. & MINKOV, M. 2010. *Cultures and organizations: software of the mind, intercultural cooperation and its importance for survival*, New York: McGraw Hill
- HOLLOWAY, I. AND FRESHWATER, D. 2007. *Narrative research in nursing*, Oxford: Blackwell Publishing
- HUDDLE, T. CENTOR, R. & HEUDEBERT, G. 2003. American internal medicine in the 21st century: can an Oslerian generalism survive? *Journal of Intern Medicine*, 18, pp764-767.
- HUGHES, I. 1996. How to keep a research diary, *Action Research Electronic Reader*, available from www.scu.edu.au/schools/gem/ar/arr/arrow/rdiary.html accessed 15/01/2010.
- HUMPHREYS, J., WAKERMAN, J., KUIPERS, P., WELLS, B., RUSSELL, D., SIEGLOFF, S., and HOMER, K. 2009. *Improving workforce retention: Developing an integrated logic model to maximise sustainability of small rural and remote health services*, Australia: The Australian National University
- ILIFFE, S., WILCOCK, J. & HAWORTH, D. 2006. Obstacles to shared care for patients with dementia: a qualitative study, *Family Practice*, 23, pp353-362.
- INTERNATIONAL COUNCIL OF NURSES (ICN). 2005. *International migration of nurses: trends and policy implications*, Geneva: ICN
- IPPR. 2006. *Hospital reconfiguration: ippr briefing*, London: IPPR.
- IVERSON, L., FARMER, J. & HANNAFORD, P. 2002, Workload pressures in rural general practice : a qualitative investigation, *Scandinavian Journal of Primary Healthcare*, 20, pp139-144.
- JACK, B. 2010. Giving them a voice: the value of qualitative research, *Nurse Researcher*, 17(3), pp4-6.
- JACK, B., HENDRY, C. & TOPPING, A. 2004. Third year student nurses perceptions of the role and impact of clinical nurse specialists: a multi-centred descriptive study, *Clinical Effectiveness in Nursing*, 8, pp39-46
- JANNINGS, W., UNDERWOOD, E., ALMER, M. & LUXFORD, B. 2010. How useful is the expert practitioner role of the clinical nurse consultant to the generalist community nurse? *Australian Journal of Advanced Nursing*, 28(2), pp33-40

- JANSEN, P., KERKSTRA, A., ABU-SAAD, H. & VAN DER ZEE, J. 1997. Differentiated practice and specialization in community nursing : a descriptive study the Netherlands, *Health and Social Care in the Community*, 5:4, pp219-225
- JIAN, G. 2012. Does culture matter? An examination of the association of immigrants' acculturation with workplace relationship quality, *Management Communication Quarterly*, 26(2), pp295-321.
- JONES, R., ROSEN, R., TOMLIN, Z., CAVANAGH, M. & OXLEY, D. 2006. General practitioners with special interests: evolution and evaluation, *Journal of Health Services Research and Policy*, 11(2), pp106-109.
- JONES, M., HUMPHREYS, J. & PRIDEAUX, D. 2009. Predicting medical students' intentions to take up rural practice after graduation, *Medical Education*, 43, pp1001-1009.
- JONES-BERRY, S. & KLEEBAUER, A. 2016. More than 10,000 empty nursing posts among NHS trusts in London, *Nursing Standard*, 13(20), p9.
- JOSEPHSSON, S., ASABA, E., JONSSON, H. AND ALSAKER. 2006. Creativity and order in communication: Implications from philosophy to narrative research concerning human occupation, *Scandinavian journal of occupational therapy*, 13, pp86-93
- JUKKALA, A., GREENWOOD, R., LADNER, K. & HOPKINS, L. 2010. The clinical nurse leader and rural hospital safety and quality, *Online Journal of Rural Nursing and Healthcare*, 10(2), pp38-44.
- KEANE, S., LINCOLN, M. & SMITH, T. 2012. Retention of allied health professionals in rural New South Wales: a thematic analysis of focus group discussions, *BMC Health Services Research*, 12(175), available from <http://www.biomedcentral.com/1472-6963/12/175> last accessed 05/02/2016.
- KEMPAINEN, R., MCKANE, E., RUBENFIELD, G., SCOTT, C. & TONELLI, M. 2010. Comparison of scholarly productivity of general and subspecialty clinicians-educators in internal medicine, *Teaching and Learning in Medicine*, 16(4), pp323-328.
- KENNEDY, H., SHANNON, M., CHUAHORM, U. & KRAVETZ, M. 2004. The landscape of caring for women: a narrative study of midwifery practice, *Journal of Midwifery and Women's Health*, 49: 1, pp 14-23
- KINGMA, M. 2007. Nurses on the move: a global overview, *Health Research and Educational Trust*, 42(3), pp1281-1298
- KINGS COLLEGE LONDON. 2009. *Providing preceptorship for newly qualified nurses: what are the components of success?*, London: Kings College London.
- KITTO, S., PELLER, J., VILLANUEVA, E., GRUEN, R. & SMITH, J. 2011. Rural surgeons' attitudes towards and usage of evidence-based medicine in rural surgical practice, *Journal of Evaluation in Clinical Practice*, 17, pp678-683.

KOCH, T. 1998. Story telling: is it really research? *Journal of Advanced nursing*, 28(6), pp1182-1190

KOELSCH, L. 2013. Reconceptualizing the member check interview, *International Journal of Qualitative Methods*, 12, pp168-179.

KRAMER, M. 1974. *Reality Shock: Why Nurses leave nursing*, St Louis: Mosby Company.

KUMAR, S. & GANTLEY, M. 1999. Tensions between policy makers and general practitioners in implementing new genetics: grounded theory interview study, *General Practice*, 319, pp1410-1413

LANDIS, S., GAYNES, B., MORRISSEY, J., VINSON, N., WLLIS, A. & DOMINO, M. 2007. Generalist care managers for the treatment of depressed Medicaid patients in north Carolina: a pilot study, *BMC Family Practice*, 8(7), available from <http://www.biomedcentral.com/1471-2296/8/7> last accessed 14/02/2016.

LANGDRIDGE, D. 2008. Phenomenology and critical social psychology: directions and debates in theory and research, *Social and Personality Psychology Compass*, 2/3, pp1126-1142

LARKIN, G. 1983. *Occupational Monopoly and Modern Medicine*. London: Tavistock. Cited in MACDONALD, K. 1995. *The sociology of the professions*, London: SAGE

LA SALA, K. 2000. Nursing workforce issues in rural and urban settings: looking at the difference in recruitment, retention and distribution, *Online Journal of Rural Nursing and Healthcare*, 1(1), pp8-17

LAW, K. & ARANDA, K. 2010. The shifting foundations of nursing, *Nurse Education Today*, 30, pp544-547

LE, Q. & KIRKPATRICK, S. 2008. Vietnamese-born health professionals: negotiating work and life in rural Australia, *Rural and Remote health*, 8(1062), available from <http://www.rrh.org.au> last accessed 05/02/2016

LEDEMA, R., LONG, D. & FORSYTH, R. 2006. Visibilising clinical work: video ethnography in the contemporary hospital, *Health Sociology Review*, 15, pp156-168

LEDWIDGE, M., TRAVERS, B., RYDER, M., RYAN, E., & MCDONALD, K. 2004. Specialist care of heart failure improves appropriate pharmacotherapy at the expense of greater polypharmacy and drug-interactions. *The European Journal of Heart Failure*, 6, pp235-243.

LEE, H. & WINTERS, C. 2004. Testing rural nursing theory: perceptions and needs of service providers, *Online Journal of Rural Nursing and Healthcare*, 4:1, pp51-63.

LEIPERT, B. & ANDERSON, E. 2012. Rural nursing education: a photovoice perspective, *Rural and Remote Health*, 12(2061), available from <http://www.rrh.org.au> last accessed 05/02/2016.

LE TOCQ, J. 2014. *Guernsey race discrimination law 'years away'*, available from <http://www.bbc.co.uk/news/world-europe-guernsey-29027883>, last accessed 10/02/2016.

LEURER, M., DONNELLY, G. & DOMM, E. 2007. Nurse retention strategies: advice from experienced registered nurses, *Journal of Health Organisation Management*, 21(3), pp307-319.

LEVETAN, C., JABLONSKI, K., PASSARO, M. & RATNER, R. 1999. Effect of physician speciality on outcomes in diabetic ketoacidosis, *Diabetes Care*, 22, pp1790-1795.

LIONIS, C. & TATSIONI, A. 2012. Conducting research in rural primary care medicine: do we need more experimental research or guidance? *Rural and Remote Health*, 12, available from <http://www.rrh.org.au> last accessed 14/02/2016.

LLOYD, C., KING, R. & MCKENNA, K. 2004. Generic versus specialist clinical work roles of occupational therapists and social workers in mental health, *Australian and New Zealand Journal of Psychiatry*, 38, pp119-124

LOWE, J., CANDLISH, P., HENRY, D., WLODARCYK, J. & FLETCHER, P. 2000. Specialist or generalist care? A study of the impact of a selective admitting policy for patients with cardiac failure, *International Journal of Quality in Healthcare*, 12:4, pp339-345

LYSGAARD, S. 1955. Adjustment in a Foreign Society: Norwegian Fulbright Grantees Visiting the United States. *International Social Science Bulletin* 7, pp45–51 cited in WARD, C., BOCHNER, S. & FURNHAM, A. 2005. *The Psychology of Culture Shock*, East Sussex: Routledge.

MACDONALD, K. 1995. *The sociology of the professions*, London: SAGE

MACDUFF, C. 2006. A follow-up study of professionals' perspectives of the development of family health nursing in Scotland: a questionnaire survey, *International Journal of Nursing Studies*, 43, pp345-356

MACLEAN, C., LOUIE, R., LEAKE, B., MCCAFFREY, D., PAULUS, H., BROOK, R. & SHEKELLE, P. 2000. Quality of care for patients with rheumatoid arthritis, *JAMA*, 284:8, PP984-992

MAGGS, C. 1983. *The origins of general nursing*, London: Croom Helm

MALINEN, S. & JOHNSTON, L. 2011, Seeking a better work-life balance: expectations and perceptions of work-related practices and attitudes of recent immigrants to New Zealand, *Asian and Pacific Migration Journal*, 20(2), pp233-252.

MALONE, J. 2012. Ethical professional practice: exploring the issues for health services to rural Aboriginal communities, *Rural and Remote Health*, 12(1891), available from <http://www.rrh.org.au>, last accessed 05/02/2016.

- MANCA, D., VARNHAGEN, S., BRETT-MACLEAN, P., ALLAN, M. & SZAFRAN, O. 2008. Respect from specialists: concerns of family physicians, *Canadian Family Physician*, 54, pp1434-5.e1-5
- MANCA, D., BREAUULT, L. & WISHART, P. 2011. A tale of two cultures: specialists and generalists sharing the load, *Canadian Family Physician*, 57, pp576-84.
- MANSKI, R., MOELLER, J., HUPP, J. & JACKSON, A. 1996. An analysis of oral surgical dentist visits by provider type, *Oral Surgery Oral Medicine Oral Pathology*, 94:6, pp 687-691
- MANTHORPE, J., ILIFFE, S. & EDEN, A. 2003. The implications of the early recognition of dementia for the multiprofessional teamworking, *Dementia*, 2:2, pp163-179
- MASGORET, A., & WARD, C. 2006. *Culture learning approach to acculturation*. In D. L. Sam, D. & Berry, J. (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 58-77). New York: Cambridge University Press.
- MCAULIFFE, T. & BARNETT, F. 2010. Perceptions towards rural and remote practice: a study of final year occupational therapy students studying in a regional university in Australia, *Australian Occupational Therapy Journal*, 57, pp293-300.
- MCCLEAN, T. 2011. *Assuring quality healthcare in rural and remote community settings: a critical analysis of the clinical governance policies developed in Guernsey, Scotland and Australia*. Guernsey: McClean
- MCCLIMENS, A., NANCARROW, S., MORAN, A., ENDERBY, P. & MITCHELL, C. 2010, Riding the bumpy seas: or the impact of the knowledge skills framework component of the agenda for change initiative on staff in intermediate care settings, *Journal of interprofessional Care*. 24(1), pp70-79.
- MCGRAIL, M., HUMPHREYS, J. & JOYCE, C. 2011. Nature of association between rural background and practice location: a comparison of general practitioners and specialists, *BMC Health Services Research*, 11(63), available from <http://www.biomedcentral.com/1472-6963/11/63> last accessed 05/02/2016.
- MCKENNA, H., KEENEY, S. & BRADLEY, M. 2003. Generic and specialist nursing roles in the community: an investigation of professional and lay values, *Health and Social Care in the Community*, 11:6, pp537-545
- MCKENZIE, H., BOUGHTON, M., HAYES, L., FORSYTH, S., DAVIES, M., UNDERWOOD, E. & MCVET, P. 2007. A sense of security for cancer patients at home: the role of community nurses, *Health and Social Care in the Community*, 15:4, pp352-359
- MCSHERRY, R. AND PEARCE, P. 2002. *Clinical Governance: a guide to implementation for healthcare professionals*, Oxford, Blackwell Publishing
- MEZIROW, J. et al, 2000. *Learning as Transformation: critical perspectives on a theory in progress*, California: Jossey-Bass Inc

MILLER, J., RAMBECK, J. & SNYDER, A. 2014. Improving emergency preparedness system readiness through simulation and interprofessional education, *Public Health Reports*, Supplement 4 vol 129. Pp129-135.

MILLS, J., FRANCIS, K. & BONNER, A. 2007. Live my work: rural nurses and their multiple perspectives of self, *Journal of Advanced Nursing*, 59(6), pp583-590.

MILLS, J., FRANCIS, K., BIRKS, M., COYLE, M., HENDERSON, S. & JONES, J. 2010. Registered nurses as members of interprofessional primary healthcare teams in remote or isolated areas of Queensland: Collaboration, communication and partnerships in practice, *Journal of Interprofessional Care*, 24(5), pp587-596.

MILLS, J., FIELD, J. & CANT, R. 2011. Rural and remote Australian general practice nurses' sources of evidence for knowledge translation: a cross sectional survey, *International Journal of Evidence-Based Healthcare*, 9, pp246-251.

MOEN, T. 2006. Reflections on the narrative research approach, *International Journal of Qualitative Methods*, 5(4), available from http://www.ualberta.ca/~iiqm/backissues/5_4/html/moen.htm last accessed 06/02/2016

MOFFAT, M., SHEIKH, A., PRICE, D., PEEL, A., WILLIAMS, S., CLELAND, J. & PINNOCK, H. 2006. Can a GP be a generalist and a specialist? Stakeholders views on a respiratory general practitioner with a special interest service in the UK, *BMC Health Services Research*, 6(62) available from <http://www.biomedcentral.com/1472-6963/6/62> last accessed 14/02/2016

MONROUXE, L. 2009. Solicited audio diaries in longitudinal narrative research: a view from inside, *Qualitative research*, 9(1), pp81-103

MONTOUR, A., BAUMANN, A., BLYTHE, J. & HUNSBERGER, M. 2009. The changing nature of nursing work in rural and small community hospitals, *Rural and Remote Health*, 9(1089), available from <http://www.rrh.org.au> last accessed 05/02/2016.

MUECKE, A., LENTHALL, S. & LINDEMAN, M. 2011. Culture shock and healthcare workers in remote indigenous communities of Australia: what do we know and how can we measure it? *Rural and Remote Health*, 11(1607), available from <http://www.rrh.org.au> last accessed 05/02/2016.

MURRAY, R. AND WRONSKI, I. 2006. When the tide goes out: health workforce in rural, remote and indigenous communities, *The medical journal of Australia*, 185(1), pp37-38

NANCARROW, S. & BORTHWICK, A. 2005. Dynamic professional boundaries in the healthcare workforce, *Sociology of Health and Illness*, pp897-919.

NANTANZON, I., SZECSENYI, J., OSE, D. & JOOS, S. 2010. Future potential country doctor: the perspectives of German GPs, *Rural and Remote Health*, 10

(1347) available from http://www.rrh.org.au/publishedarticles/article_print_1347.pdf last accessed 05/02/2016.

NAYDA, R. & CHERI, J. 2008. From enrolled nurse to registered nurse in the rural setting: the graduate nurse experience, *Rural and Remote Health*, 8(900), available from <http://www.rrh.org.au> last accessed 05/02/2016.

NEWMAN, K., MAYLOR, U. & CHANSARKAR, B. 2002. The nurse satisfaction , service quality and nurse retention chain: implications for management of recruitment and retention, *Journal of Management in Medicine*, 16(4), pp271-291.

NEWTON, S., PILLAY, J. & HIGGINBOTTOM, G. 2012. The migration and transitioning experiences of internationally educated nurses: a global perspective, *Journal of Nursing Management*, 20, pp534-550.

NHS. 2009. *The NHS information centre for health and social care vacancies survey*, available at www.ic.nhs.uk/ accessed 26/6/10

NHS. 2013. *NHS Services, seven days a week forum: Initial findings*, England:NHS

NHS EMPLOYERS, 2013. *Using Social Media in your recruitment process: the essential guide for HR directors and managers*, available from www.nhsemployers.org/publications last accessed 10/02/2016

NHS SCOTLAND 2005. *The national framework for service change in NHS Scotland: final report*, Scotland:NHS Scotland

NHS SCOTLAND 2007. *Better Health, better care: action plan*, Scotland: NHS Scotland

NURSING AND MIDWIFERY COUNCIL. 2015a. *The Code: professional standards of practice and behaviour for nurses and midwives*, London: NMC

NMC 2015b. *Extraordinary LSA follow up review: Princess Elizabeth Hospital, health and Social Services Department, Guernsey 02-04 November 2015*, London: NMC

NMC 2014. *Additional evidence obtained during the extraordinary review: Princess Elizabeth Hospital, health and Social Services Department, Guernsey 01-03 October 2014*, London: NMC

NOCON, A. & LEESE, A. 2004. The role of UK general practitioners with special clinical interests: implications for policy and service delivery, *British Journal of General Practice*, 54, pp50-56

NOONAN, D. 2013. Preparing and conducting interviews to collect data, *Nurse Researcher*, 20(5), pp28-32.

NUGUS, P., GREENFIELD, D., TRAVAGLIA, J., WESTBROOK, J. & BRAITHWAITE, J. 2010. How and where clinicians exercise power: interprofessional relations in healthcare, *Social Science and Medicine*, 71, pp898-909.

OBERG K. 1960. Cultural shock: adjustment to new cultural environments. *Practical Anthropology*, 7, pp177-182. cited in MUECKE, A., LENTHALL, S. & LINDEMAN, M. 2011. Culture shock and healthcare workers in remote indigenous communities of Australia: what do we know and how can we measure it? *Rural and Remote Health*, 11(1607), available from <http://www.rrh.org.au> last accessed 05/02/2016.

OBERSKI, I., CARTER, D., GRAY, M. & ROSS, J. 1999. The community gerontological nurse: themes from a needs analysis, *Journal of Advanced Nursing*, 29(2), pp454-462.

OLIFFE, J., BOTTORFF, J., KELLY, M. & HALPIN, M. 2008. Analyzing participant produced photographs from an ethnographic study of fatherhood and smoking, *Research in Nursing and Health*, 31(5), pp529-539.

OLIVER, A. AND MOSSIALOS. 2005. European health systems reforms: looking backward to see forward? *Journal of health politics, policy and law*, 30: 1-2, pp7-28.

O'NEILL, F. 2011. From language classroom to clinical context: the role of language and culture in communication for nurses using English as a second language: a thematic analysis. *International Journal of Nursing Studies*, 48, pp1120-1128

ORBUCH, T. 1997. People's accounts count: the sociology of accounts, *Annual Reviews in Sociology*, 23, pp455-478

OVERCASH, J. 2003. Narrative research: a review of methodology and relevance to clinical practice, *Critical Reviews in Oncology/Haematology*, 48, pp179-184.

PADILLA, A. & PEREZ, W. 2003, Acculturation, social identity, and social cognition: A new perspective, *Hispanic Journal of Behavioural Sciences*, 25(1), pp35-55

PALESE, A., BARBA, M., BORGHI, G., MESAGLIO, M. & BRUSAFERRO, S. 2006. Romania nurses' process of adaptation to Italian nursing practices during their first six months in Italy: a qualitative study, *Diversity in Health and Social care*, 3, pp123-130.

PALIADELIS, P., PARMENTER, G., PARKER, V., GILES, M. & HIGGINS, I. 2012, The challenges of confronting clinicians in rural acute care settings: a participatory research project, *Rural and Remote Health*, 12(2017) available from <http://www.rrh.org.au> last accessed 05/02/2016.

PALMER, V., NACCARELLA, L. & GUNN, J. 2007. Are you my generalist or the specialist of my care? *NZFP*, 34(6), pp395-397

PALMO, M. 2010. *Critical hermeneutic participatory research protocol: exploring the creative process of community art development in Uganda*, San Francisco: University of San Francisco.

PARKIN, F. (1979), *Marxism and Class Theory: A Bourgeois Critique*, Cambridge: Tavistock.

- PASHEN, D., CHATER, B., MURRAY, R., SHEEDY, V., WHITE, C., ERIKSSON, L., DE LA RUE, S. & DU RIETZ, M. 2007. *The expanding role of the rural generalist in Australia – a systematic review*, Australia: ANU
- PATHAM, D., KONRAD, T., DANN, R. & KOCH, G. 2004. Retention of primary care physicians in rural health professional shortage areas, *American Journal of Public Health*, 94(10), pp1723-1729.
- PATTERSON, M. & WILLIAMS, D. 2002. *Collecting and analyzing qualitative data: hermeneutic principles, methods and case examples*, Illinois: Sagamore Publishing.
- PATTON, M. 1990. *Qualitative evaluation and research methods*, Beverley Hills: Sage.
- PATTON, M. 2002. *Qualitative Research and Evaluation Methods*, 3rd ed, California: sage
- PAULUS, A., VAN RAAK, A. & KEIJZER, F. 2006. Nursing home care: whodunit? *Journal of Clinical Nursing*, 15, pp1426-1439
- PAYNE, S., SHELDON, F., JARRETT, N., LARGE, S., SMITH, P., DAVIS, C., TURNER, P. & GEORGE, S. 2002. Differences in understanding of specialist palliative care amongst service providers and commissioners in south London, *Palliative Medicine*, 16, pp395-402.
- PEARSON, A. 2003. Multidisciplinary nursing: rethinking role boundaries, *Journal of Clinical Nursing*, 12, pp625-629.
- PELLATT, G. 2003. Ethnography and reflexivity: emotions and feelings in fieldwork, *Nurse Researcher*, 10(3), pp28-37.
- PEREIRA, G. 2005. Palliative care in the hinterlands: a description of existing services and doctors' attitudes, *Australian Journal of Rural Health*, 13, pp343-347.
- PHOENIX, C. AND SPARKES, A. 2009. Being fred: big stories, small stories and the accomplishment of a positive ageing identity, *Qualitative Research*, 9(2), pp219-236
- PIERCE, C. & SCHERRA, E. 2004. The challenges of data collection in rural dwelling samples, *On-line Journal of Rural Nursing and Healthcare*, 4(2), pp 25- 30.
- PILLAY, R. 2009. Retention strategies for professional nurses in South Africa, *Leadership in Health Services* 22(1), pp39-57
- PINNOCK, H., NETUVELI, G., PRICE, D. & SHEIKH, A. 2005. General practitioners with a special interest in respiratory medicine: national survey of UK primary care organisations, *BMC Health Services Research*, 5(40), available from <http://www.biomedcentral.com/1472-6963/5/40> last accessed 15/02/2016
- PORTER, S. 1998. *Social theory and nursing practice*, London: Macmillan Press Ltd
- POST, P., WITTENBERG, J. & BURGERS, J. 2009. Do specialized centres and specialists produce better outcomes for patients with chronic diseases than primary

care generalists? AQ systematic review, *International Journal of Quality in Healthcare*, 21(6), pp387-396.

POWELL, A. & DAVIES, H. 2012. The struggle to improve patient care in the face of professional boundaries, *Social Services and Medicine*, 75, pp807-814.

PRIESTER, R. & REINARDY, J. 2003. Recruiting immigrants for long-term care nursing positions, *Journal of Aging and Social Policy*, 15(4), available from <http://www.haworthpress.com/store/product.asp?sku=J031> last accessed 05/02/2016.

PURVIS, L. & CROPLEY, M. 2003. The psychological contracts of National Health service Nurses, *Journal of Nursing management*, 11, pp107-120.

PUTNAM, R. 2001, *Social Capital: measurement and consequences*, USA: Harvard University.

RAGHURAM, P. 2007. Interrogating the language of integration: the case of internationally recruited nurses, *Journal of Clinical Nursing*, 16, pp2246-2251.

RAMRITU, P., COURTNEY, M., STANLEY, T. & FINALYSON, K. 2002. Experiences of the generalist nurse caring for adolescents with mental health problems, *Journal of Child Healthcare*, 6(4), pp229-244.

REISS, S., HOLUBKOV, R., EDMUNDOWICZ, D., MCNAMARA, D., ZELL, K., DETRE, K. & FELDMAN, A. 1997. Treatment of patients admitted to the hospital with congestive heart failure: speciality-related disparities in practice patterns and outcomes, *JACC*, 30(3), pp733-738

RITCHIE, K., DOWNIE, S. BOYNTON, J. AND WARNER, J. 2005 Clinical governance: what does it mean for NHS Scotland? *Scottish Medical Journal*, 50:4, pp147-149.

RILEY, T. & HAWES, P. 2005. Researching practice: the methodological case for narrative enquiry, *Health Education Research*, 20: 2, pp226-236

RIVETT, G. 2016. *National health service history*, www.nhshistory.net, most recently accessed 04/02/16

ROBINSON, L., VELLAS, B., KNOW, S. & LINS, K. 2010, Clinical practice patterns of generalists and specialists in alzheimer's disease: what are the differences, and what difference to they make? *The Journal of Nutrition, Health and Aging* 14(7), pp545-552.

ROSE, J. & GLASS, N. 2010. An Australian investigation of emotional work, emotional well-being and professional practice: an emancipatory inquiry, *Journal of Clinical Nursing*, 19, pp1405-1414

ROSENTHAL, K. 2005. What nursing stories are you living? *Online Journal of Rural Nursing and Healthcare*, 5:1, pp37-47

ROYAL COLLEGE OF NURSING. 2013. *RCN Factsheet: specialist nursing in the UK*, available from [http://www.apollonursingresource.com/wp-content/uploads/2013/10/4.13 RCN Factsheet on Specialist nursing in UK - 2013.pdf](http://www.apollonursingresource.com/wp-content/uploads/2013/10/4.13_RCN_Factsheet_on_Specialist_nursing_in_UK_-_2013.pdf), last accessed 05/02/2016.

ROYAL COLLEGE OF NURSING 2015. *RCN London safe staffing report 2015*, London: RCN

ROYAL COLLEGE OF GENERAL PRACTITIONERS 2013. *GP with a special interest accreditation* available from <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/gp-with-a-special-interest-gpws-i-accreditation.aspx> last accessed 05/02/2016.

ROYAL COLLEGE OF PHYSICIANS. 1996. *The future patterns of care by general and specialist physicians*, London: RCP.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH. 2005. *Personal perspectives on the future of remote and rural medicine in Scotland: a series of commissioned commentaries*, Scotland: RCPE.

ROYAL COLLEGE OF SURGEONS OF ENGLAND. 2006. *Delivering High-quality Surgical Services for the Future: A consultation document from the Royal College of Surgeons of England Reconfiguration Working Party*, England: RCSE.

SAM, D. 2006. *Acculturation: conceptual background*. In D. L. Sam, D., & Berry, J. (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 11-26). New York: Cambridge University Press.

SANDELOWSKI, M. 1999. Time and qualitative research, *Research in Nursing and Health*, 22, pp79-87.

SARRAH. 2008. *Literature review supporting the transition of allied health professionals to remote and rural practice*, Adelaide: CAHE

SCALLY, B. AND DONALDSON, L. 1998. Clinical governance and the drive for quality improvement in the new NHS in England, *British Medical Journal*, 317: 7150, pp61-5

SCHROEDER, S. 2002. Primary care at a crossroad, *American Medicine*, 77(8), pp767-773.

SCOTLAND- the official online gateway. 2006. *Population of Scotland facts*, available from www.scotland.org/about/fact-file/population/index.html

SCOTTISH GOVERNMENT. 2003. Social focus on urban rural Scotland available from www.scotland.gov.uk/Publications/2003/05/17207/22175 accessed 16/06/10.

SCOTTISH GOVERNMENT. 2007. *Delivering for remote and rural healthcare: the final report of the remote and rural workstream*, Edinburgh: Scottish Government

SEMPOWSKI, I. 2004. Effectiveness of financial incentives in exchange for rural and underserved area return-of-service commitments: systematic review of the literature, *Canadian Journal of Rural Medicine*, 9(2), pp82-88.

SHERMAN, R. & EGGENBERGER, T. 2008. Transitionally internationally recruited nurses into clinical settings, *Journal of Continuing Education in Nursing*, 39(12), pp535-544.

SHIPMAN, C., ADDINGTON-HALL, S., BRIGGS, J., COX, I., DANIELS, L. & MILLAR, D. 2002. How and why do GPs use specialist palliative care services? *Palliative Medicine*, 16, pp241-246.

SHIPMAN, C., GYSELS, M., WHITE, P., WORTH, A., MURRAY, S., BARCLAY, S., FORREST, S., SHEPHERS, J., DALE, J., DEWAR, S., PETERS, M., WHITE, S., RICHARDSON, A., LORENZ, K., KOFFMAN, J. & HIGGINSON, I. 2008. Improving generalist end of life care: national consultation with practitioners, commissioners, academics and service user groups, *BMJ*, 337(a1720) available from <http://www.bmj.com.ezproxy1.bath.ac.uk/archive/online/1998> last accessed 14/02/2016.

SIDEBOTHAM, M. & AHERN, K. 2011. Finding a way: the experiences of UK educated midwives finding their place in the midwifery workforce in Australia, *Midwifery*, 27, pp316-323.

SILVERMAN, D. 2000. *Doing qualitative research: a practical handbook* London: SAGE

SILVERMAN, D. 2001. *Interpreting qualitative data; methods for analysing talk, text and interaction*, 2nd ed. London: SAGE

SIMINERIO, L., FUNNELL, M., PEYROT, M. & RUBIN, R. 2007. US nurses' perceptions of their role in diabetes care: results of the cross-national diabetes attitudes wishes and needs (DAWN) study, *The Diabetes Educator*, 33:1, pp152-162

SLAGLE, D., BYINGTON, R. & VERHOVSEK, E. 2012, Rural versus urban: Tennessee health administrators' strategies on recruitment and retention for allied health professionals, *Journal of Healthcare Finance*, 38(4), pp91-104.

SMETANA, G., LANDON, B., BINDMAN, A., BURSTIN, H., DAVIS, R., TJIA, J. & RICH, E. 2007. A comparison of outcomes resulting from generalist vs specialist care for a single discrete medical condition: a systematic review and methodological critique, *Archives Intern Medicine*, 167, pp10-20

SMITH, A. 1776. *The wealth of nations*, London: Strahan and Cadell cited in DURKHEIM, E. [1893]1984. *The division of labour in society*, New York: Palgrave.

SMITH, S. & CAMPBELL, N. 2004. Provision of oncology services in remote rural areas: a Scottish perspective, *European Journal of Cancer Care*, 13, pp185-192.

SOCHAN, A. & SINGH, M. 2007. Acculturation and socialization: voices of internationally educated nurses in Ontario, *International Nursing Review*, 54, pp130-136.

SQUIRE, C. 2008. Chapter 2: experience-centred and culturally-oriented approaches to narrative, in ANDREWS, M., SQUIRE, C. AND TAMBOUKOU, M. eds. *Doing narrative research*, London: SAGE. Pp41-63.

STATES OF GUERNSEY. 1987. *The Nurses, Midwives and Health Visitors Ordinance*, Guernsey: SoG

STATES OF GUERNSEY. 2001. *Data protection (Bailiwick of Guernsey) law, 2001*, Guernsey: SoG

STATES OF GUERNSEY 2016. *Financial transformation programme*, available from <http://theoldsite.gov.gg/ftp> last accessed 13/02/2016.

STEVENS, R. 1966. *Medical practice in modern England: the impact of specialization & state medicine*, London: The Vail-Ballou Press Inc.

STILLE, C., PRIMACK, W. & SAVAGEAU, J. 2003. Generalist-specialist communication for children with chronic conditions: a regional physician survey, *Pediatrics*, 112(6), pp1314-1320

STILLE, C., JERANT, A., BELL, D., MELTZER, D. & ELMORE, J. 2005. Co-ordinating care across diseases, settings, and clinicians: A key role for the generalist in practice, *Annals of Internal Medicine*, 142, pp700-708.

STRASSER, R., HOGENBIRK, J., LEWENBERG, M., STORY, M. & KEVAT, A. 2010. Starting rural, staying rural: how can we strengthen the pathway from rural upbringing to rural practice, *The Australian Journal of Rural Health*, 18, pp242-248.

SULLIVAN, E., FRANCIS, K & HEGNEY, D. 2008. Review of small rural health services in Victoria: how does the nursing-medical division of labour affect access to emergency care? *Journal of Clinical Nursing*, 17, pp1543-1552.

SVENSSON. R. 1996. The interplay between doctors and nurses –a negotiated order perspective, *Sociology of health and illness*, 18, pp379-398.

SWARZTRAUBER, K., VICKREY, B. & MITTMAN, B. 2002. Physicians' preferences for speciality involvement in the care of patients with neurological conditions, *Medical Care*, 40(12), pp1196-1209.

SYRJALA, J., TAKALA, T. AND SINTONEN, T. 2009. Narratives as a tool to study personnel wellbeing in corporate mergers, *Qualitative research*, 9(3), pp263-284

THOMAS, D., MACDOWELL, M. & GLASSER, M. 2012, Rural mental health workforce needs assessment – a national survey, *Rural and Remote Health*, 12, available from <http://www.rrh.org.au> last accessed 15/02/2016.

- TRAYNOR, M. 2013. *Nursing in Context: Policy, politics, profession*, Hampshire: Palgrave Macmillan
- VAN OUDENHOVEN, J. 2006. *Immigrants* in D. L. Sam, D. & Berry, J. (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 163-180). New York: Cambridge University Press.
- VEITCH, C., DEW, A., LINCOLN, M., BUNDY, A., GALLEGGO, G. & GRIFFITHS, S. 2012 Issues affecting therapist workforce and service delivery in the disability sector in rural and remote New South Wales, Australia: perspectives of policy makers, managers and senior therapists, *Rural and Remote Health*, 12(1907)available from available from <http://www.rrh.org.au> last accessed 05/02/2016.
- VUKIC, A. & KEDDY, B. 2002. Northern practice in a primary healthcare setting, *Journal of Advanced Nursing*, 40(5), pp542-548.
- WARD, C., BOCHNER, S. & FURNHAM, A. 2005. *The Psychology of Culture Shock*, East Sussex: Routledge.
- WARNE, T. & MCANDREW, S. 2010. Researching for therapy: the ethics of what we are skilled in, *Journal of psychiatric and Mental Health Nursing*, 17, pp503-509.
- WATSON, T. 1995. *Sociology, work and industry*, 3rd edition, New York:Routledge
- WEBB, C. 1992. The use of the first person in academic writing: objectivity, language and gatekeeping, *Journal of Advanced Nursing*, 17, pp747-752.
- WEBER, M. 1978 [1921]. *Economy and society*, CA: University of California Press cited in MACIONIS, J. & PLUMMER, K. 2002. *Sociology: a global introduction*, 2nd ed. Essex: Prentice Hall
- WEISS ROBERTS, L., BATTAGLIA, J. & EPSTEIN, R. 1999. Frontier ethics: mental healthcare needs and ethical dilemmas in rural communities, *Psychiatric Services*, 50:4, pp497-503
- WEISZ, G. 2006. *Divide and conquer: a comparative history of medical specialisation*, Oxford: Oxford University Press
- WHILE, A. 2005. In defence of nursing and the generic nurse, *International Journal of Nursing Studies*, 42, pp715-716
- WHITE, R. 1985. *The effects of the NHS on the nursing profession 1948-1961*, London: Oxford University Press.
- WILENSKY, H. 1964. The professionalization of everyone? *The American Journal of Sociology*, 70(2), pp137-158
- WILLIAMS, E., D'AMORE, W. & MCKEEN, J. 2007. Physiotherapy in rural and regional Australia, *Australian Journal of Rural Health*, 15, pp380-386.

WILSON, R. 2007. Out back and out-of –whack: issues related to the experience of early psychosis in the New England region, new south wales, Australia, *Rural and Remote Health*, 7:715, available from www.rrh.org.au accessed on 4/2/10.

WITZ, A. 1992. *Professions and patriarchy*, New York: Routledge cited in MACDONALD, K. 1995. *The sociology of the professions*, London: SAGE

WOLSTENCROFT, K. & MACVICAR, R. 2011. A taste of rural highlands and islands general practice: evaluation of remote placements in GP speciality training, *Education for Primary Care*, 22, p83-89

WOODBIDGE, M. & BLAND, M. 2010. Supporting Indian nurses migrating to New Zealand: a literature review, *International Nursing Review*, 57, pp40-48.

WOODHOUSE, G. 2009. Exploration of interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting, *Australian Journal of Advanced Nursing*, 26:3, pp17-23

WOODHOUSE, J. 2012. The use of visual methodology in nursing, *Nurse Researcher*, 19(3), pp20-25.

WORLD HEALTH ORGANISATION. 2006. Health workers: a global profile, Geneva: WHO

WORLD HEALTH ORGANISATION. 2010. *WHO global code of practice on the international recruitment of health personnel*, Geneva: WHO

XAKELLIS, G. 2005. Are patients who use a generalist physician healthier than those who seek speciality care directly? *Family Medicine*, 37:10, pp719-726

XIA, J. 2009. Analysis of impact of culture shock on individual psychology, *International Journal of Psychological Studies*, 1(2), pp97-101

XU, Y. 2005. Clinical challenges of Asian nurses in a foreign healthcare environment, *Home Healthcare Management Practice*, 17, pp492-494.

YATES, K., KELLY, J., LINDSAY, D. & USHER, K. 2012. The experience of rural midwives in dual roles as nurse and midwife: "I'd prefer midwifery but chose to live here", *Women and Birth*, available from www.elsevier.com/locate/wombi, last accessed 05/02/2016.

YI, M. & JEZEWSKI, M. 2000. Korean nurses' adjustment to hospitals in the United States of America, *Journal of Advanced Nursing*, 32(3), pp721-729.

YOUNG, S., BARTRAM, T. & STANTON, P. 2010. High performance work systems and employee well-being: a two-stage study of a rural Australian hospital, *Journal of Health Organisation and Management*, 24(2), pp182-199

YUKIE, A., KAWAHARA, C., YAMASHINA, A. & TSUBOI, R. 2013. Repeated scenario simulation to improve competency in critical care: a new approach for nursing education, *American Journal of Critical Care*, 22(1), pp33-40

ZENTLER-MUNRO, P. 2005. Remote and rural medicine: excellence from the edge in RCPE *Personal perspectives on the future of remote and rural medicine in Scotland*, Scotland: RCPE.

Appendix one: Letter sent to long serving participants



28th October 2012

Dear

I am a lecturer based at the Institute of Health and Social Care Studies (IHSCS). I am currently undertaking a Professional Doctorate in Health with the University of Bath. My research thesis is focused on the challenges newly appointed Registered Nurses (RN) experience when they take up post in Guernsey or Alderney. As part of this process I would like to explore the experiences of RNs who have been in post for at least 5 years and have achieved the 'expert' level that the new recruits aspire to. I am looking to recruit individuals to the study who meet the following criteria;

- RN holding a generalist post; the post-holder may be registered on any part of the register.
- RN has been in post for a minimum of 5 years

I have included an information sheet about the research for you to read and help you decide as to whether you wish to take part or not.

I shall be contacting you again in the next couple of weeks to see whether you are interested in taking part and would like to meet with me to discuss the research requirements further. Although you will be asked to sign a consent form you will be able to withdraw from the study at any time without any repercussions to you or your position here in the organization.

If you want to speak to me about this study before I next contact you, please call me on ext 4647,
direct line 707447
or email me at tmcclean@health.gov.gg.

I look forward to speaking to you in the near future,

Yours sincerely

Tracey McClean MSc, BSc, PGCE, DPSN, DHSM, RN.
Academic lead post-qualifying programme

Appendix two: Letter sent to New Employees



4th July 2012

Dear xxxxx

I am a lecturer based at the Institute of Health and Social Care Studies (IHSCS). I am currently undertaking a Professional Doctorate in Health with the University of Bath. My research thesis is focused on the challenges newly appointed Registered Nurses (RN) experience when they take up post in Guernsey or Alderney. I am looking to recruit individuals to the study who meet the following criteria;

- RN holding a generalist post; the post-holder may be registered as adult, mental health, children or learning disabilities
- RN has been in post for less than 24 months
- RN has no previous experience of working or living in Guernsey or Alderney.

These participants will be newly recruited RNs and have been selected to capture their initial experiences of working and living in either Guernsey or Alderney and I believe you meet these criteria.

I have included an information sheet about the research for you to read and help you decide as to whether you wish to take part or not.

I shall be contacting you again in the next couple of weeks to see whether you are interested in taking part and would like to meet with me to discuss the research requirements further. Although you will be asked to sign a consent form you will be able to withdraw from the study at any time without any repercussions to you or your position here in the organization.


If you want to speak to me about this study before I next contact you, please call me on ext 4647,
direct line 707447
or email me at tmcclean@health.gov.gg.

I look forward to speaking to you in the near future,
Yours sincerely

Tracey McClean MSc, BSc, PGCE, DPSN, DHSM, RN.
Academic lead post-qualifying programmes

Appendix three: Information sheet

Do you want to tell your story?



And make a difference to the recruitment and retention of staff?

WHY WOULD YOU BE TELLING YOUR STORY?

I am Tracey McClean, one of the lecturers based at the Institute of Health and Social Care Studies. I am studying for a Professional Doctorate in Health with the University of Bath. I am very interested in the challenges that Registered Nurses face when they take up post in Guernsey or Alderney, especially if they have had no experience of working in the Islands before.

I have completed a literature review which indicates that working in small communities like ours has its own unique challenges and that many other remote, rural or underserved areas like the Highlands of Scotland have similar recruitment and retention problems to the ones we experience. Story-telling or narrative research is a valid way of capturing the experiences people have when they take up post in the Islands (Rosenthal, 2005). This approach takes into account that your story is very much shaped by your own unique position, the experiences you have had and the context you are working in. I would like to capture your story and then work with you to interpret it to gain an understanding of what you perceive to be the key challenges of living and working in the islands. In other words..what is it really like working in an island?

I will be inviting Registered Nurses to take part who have either taken up post in the last 12 months or have been in post for more than 5 years. There will be participants from both Alderney and Guernsey. Once the stories of the participants have been analysed, the findings will be used to:

- Identify the challenges facing newly appointed RNs during the first twelve months of appointment.
- Establish the scope of the occupational role of the generalist 'expert' nurse employed in two small island communities and explicate the challenges they continue to face in their role.
- Identify strategies to prepare and support RNs to meet the challenges they may face when taking up post in a small island community.
- Contribute to the identification of the professional development needs and support required for generalist RNs to achieve 'expertise' in their professional roles within a small island community
- Give 'voice' to the 'work' of the generalist RN employed in two small island communities

Direct line 707 447

2

You will be required to compile a story which encapsulates your experiences of living and

You will be expected to complete your story

Once you have submitted your story, you will be

participants have provided.

TRACEY

Appendix four: Consent form



Participant Informed Consent Form

Dear Prospective Research Participant

Thank you for considering to take part in my research study. Please read the information leaflet you have been given and the information contained on this form before you sign it. Feel free to ask questions about your part in the research before deciding if you want to be involved in the study. Thank you for your time.

Tracey McClean,
Lead researcher

PURPOSE OF THIS RESEARCH STUDY

The purpose of this study is to explore the challenges that newly appointed Registered Nurses (RNs) face when they take up post in Alderney or Guernsey. The study findings will be used to identify strategies which could be put in place to improve the recruitment and retention of RNs in both islands.

WHAT WILL YOU NEED TO DO?

You will be required to 'tell your story' of your experiences of living and working in the islands.

You will be asked to use visual, written or verbal media to record your story. The information leaflet gives further guidance as to how you can use these media to provide a rich account of your experiences.

When you have recorded your story, you will have an interview with me to discuss it. This interview will be used as an opportunity to clarify the content of your story and to give you another chance to add further detail if you wish. You will also be asked to provide a little more information about your background as this is an important factor to consider when analyzing your story. This will take 1 hour

You will have control over the nature of the data used and the information that is published. You will be asked to comment on the final analysis which will include a comparison of the individual interpretations of the participants.

POSSIBLE RISKS

There are two key risks associated with this research:

The first is the issue of maintaining your anonymity. Although you will not be directly identified in the published study, the fact that the communities are small and the nature of the research is detailed in terms of the context within which it takes place, will make it more likely that your contribution will be identified by local staff reading the final report. However you will have control over the data that is published and your wishes will be respected in the final report.

The second is the issue of having to revisit difficult experiences which you may find distressing. Again you will be given full support during the research, with the opportunity to de-brief after our discussions and access to the expertise from Human Resources/Occupational Health if you require extra support. You may find the research process therapeutic, however if you reveal anything that you do not want to be included as data, that information will remain confidential.

POSSIBLE BENEFITS

It is anticipated that this study will provide valuable data to inform the way we recruit and retain staff within the Islands. Hopefully you will benefit from the experience of taking part in this study as you will be fully involved in the research process.

FINANCIAL CONSIDERATIONS

At present I am unable to offer you any financial reward for taking part and you may not be able to be released for this study or receive time in lieu. However we will keep a log of your involvement and if you wish I will write a testimonial of your input into this study

CONFIDENTIALITY

As stated above confidentiality will be maintained. Your data will either be stored on the computer (password protected) or in a locked cupboard in my office. However it needs to be highlighted here that any issues raised which have implications for patient safety will need to be dealt with in accordance with our professional code (NMC 2008).

TERMINATION OF RESEARCH STUDY

You can choose to participate in this study or withdraw at any time if you wish, without any detriment to your employment in the organization. You will be given a copy of the final report which may include your name if you wish, as the construction of this study is due to your valuable contribution.

CONTACT DETAILS

I can be contacted on the following:

Direct line: 707447

Int ext: 4647

e-mail internal and external tmcclean@ health.gov.gg

mobile: 07781111373.

I am based at the above address detailed on the headed paper.

AUTHORIZATION

I have read and understand this consent form, and I volunteer to participate in this research study

PARTICIPANT'S NAME:

SIGNATURE:

Date:

Lead Investigator Signature:

Date:

Appendix five: Follow up letter



Dear

Many thanks for agreeing to take part in my research study; I hope you enjoy taking part. Please find enclosed a copy of your consent form for your information.

As we discussed I would like you to do the following:

- 1) Provide an account of your experiences of living and working in Guernsey. You can either write this account and e-mail it to me or tape record it if you prefer. In addition you can take photos to help you to capture your experiences.
- 2) The account can include examples of some of the challenges you have faced so far and how you have felt about them. This can include both positive and negative experiences.
- 3) After you have completed your account, we will meet again for about an hour to discuss your story. This will take the form of a semi-structured interview. I will tape record this and transcribe it.
- 4) The information you provide will be analysed by me and included in my research unless you have any objections.
- 5) I hope to complete all the interviews by the end of October, so it would be helpful for you to get your account to me by the end of September.

Once again many thanks for your help, my contact details are on the consent form

Tracey

Appendix six Interview script (new recruits)- October 12th 2012

Introduction/background

1) Can you tell me who you are and where you come from?

2) Can you tell me a little bit about your background?

3) Explain how you came to be in Guernsey?

- what influenced their decision
- what were their feelings about taking up post on an island

Exploring the topic

4) Can you give some examples of how your professional role in Guernsey differs from other posts you have held in the past?

- are they wider and more generalist
- have they lost skills
- any role boundary issues with other professional groups ie level of autonomy
- organisational issues
- feelings of isolation
- ethical issues
- cultural differences

Try to tease out vignettes

5) How about living on the Island, can you give some examples of the challenges you have faced so far?

- acculturation
- cost/housing
- role boundaries

Try to tease out good and bad!

6) What has helped you to deal with some of the challenges you have faced so far, both in your professional role and as a resident on the island?

7) What could have helped you with your move to Guernsey and getting used to working and living here?

Conclusion

8) What do you think about your experiences so far?

- do these differ from what you expected
- why do you feel the way you do
- are there any additional issues or factors which may have influenced your experiences

Appendix seven Interview script (experts) - November 12th 2012

Introduction/background

1) Can you tell me who you are and where you come from?

2) Can you tell me a little bit about your background?

3) Explain how you came to be in Guernsey?

- what influenced their decision

- what were their feelings about taking up post on an island

Exploring the topic

4) Can you give some examples of how your professional role in Guernsey differs from other posts you have held in the past?

- are they wider and more generalist

- have they lost skills

- any role boundary issues with other professional groups ie level of autonomy

- organisational issues

- feelings of isolation

- ethical issues

- cultural differences

- CPD/career opportunities

Try to tease out vignettes

5) How about living on the Island, can you give some examples of the challenges you have faced so far?

- acculturation

- cost/housing

- role boundaries

Try to tease out good and bad!

6) What has helped you to deal with some of the challenges you have faced so far, both in your professional role and as a resident on the island?

7) Do you think these challenges have changed during your time on the Island?

8) What sorts of issues do you think new recruits face when taking up post on the Island ?

9) Do you think we support staff enough in making the transition to their new roles and island life?

10) What would help you as an expert professional to meet the challenges you face as you continue to practice on the Island both now and in the future?

Appendix eight – the complex relationship between the nodes

